Minneapolis Clinic of Neurology

REHABILITATION SERVICES

Dear Patient:

Welcome and thank you for choosing Burnsville Physical Therapy for your rehabilitative care. Please take a few minutes to review and complete the following information **prior** to your visit.

1. Appointments: Enclosed is an appointment reminder card for your convenience. We make every effort to be on time for our patient's appointments and ask that you extend the same courtesy to us. For those who cancel so late we cannot offer the time to another patients or for those who fail to keep their appointments, we will not be able to make future appointments with you. **If you miss two appointments without advanced notice, we will not be able to schedule further appointments for you. You may also be charged a $50 fee for late cancels or no shows.**

2. Physician's Physical Therapy Prescription: Please bring your physician's written order for physical therapy to your first appointment. If we contacted you to schedule the initial physical therapy appointment, we already have your prescription.

3. Physical Therapy History/Subjective Information Form: This information will assist our therapists in providing you with the best possible care. Make sure to bring it along on your first appointment.

4. Health Insurance Benefits Worksheet: We suggest that you contact your insurance company before starting physical therapy to determine the extent of coverage for these services. Our worksheet provides you with a quick checklist of important questions to ask before your appointment. **It is the patient's responsibility to know the benefit information for their health insurance. If you have questions, please call them.**

5. Co-Payments: are due at the time of visit. If you have a deductible, we will not know the amount you owe until after your insurance company makes payments. Then our office will bill you the amount.

6. On the first visit, you will be seen by a **physical therapist**. The next visits you will be seen by either the **same physical therapist or his/her assistant**. They work as a team in order to offer you more availability for appointments to meet your needs.

Please make sure to have all these forms filled out before you come in.

Thank you for your cooperation. Please feel free to contact us at 952-898-5000, should you have any questions regarding this information or your upcoming visit to our clinic.

Sincerely,

The Burnsville Physical Therapy Staff

BURNSVILLE OFFICE
Oak Ridge East Professional Bldg.
675 E. Nicollet Blvd., Suite 100
Burnsville, MN 55337-6749
Phone: 952-898-5000
Fax: 952-898-5996

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Fax: 763-287-2309

MAPLE GROVE OFFICE
North Memorial Medical Office
9825 Hospital Drive, Suite 103
Maple Grove, MN 55369-4200
Phone: 763-302-4114
Fax: 763-420-3175

MINNEAPOLIS CLINIC OF NEUROLOGY, LTD.

CREDIT POLICY

Thank you for choosing the Minneapolis Clinic of Neurology, Ltd. for your medical care.

We participate in most insurance plans and will bill your insurance company directly for our services. It is your responsibility to determine if we are participating providers in your plan.

Many changes have taken place in the health insurance industry in recent years. Since every plan is different, be sure to check your coverage if you have specific questions about what your insurance will pay.

Your insurance company requires that you present your insurance card at each and every visit.

Copayments, which are usually listed on your insurance card, are due at the time of service. We are required by your insurance carrier to collect co-payments. If you do not pay your co-payment at the time of service, a $20.00 service charge will be applied to your account to cover the costs of billing and processing. Your co-payment could increase without a new card being issued to you. Your insurance company can tell you what your co-payment is.

We will mail you a statement of your account, which is due upon receipt. Your insurance company determines any balance due. Many people have policies with only partial coverage. This may mean that you will pay more out of your own pocket than you have in the past. We accept cash, checks, money orders, debit cards and all major credit cards. A 1.5% monthly finance charge will be added to all accounts with any remaining balances over 30 days old. Limited financial arrangements may be made only by speaking to one of our Patient Financial Services Representatives.

While we make every effort to resolve insurance issues, please remember that you are ultimately responsible for the cost of your health care.

If you need to cancel your appointment, please notify our office 24 hours before your appointment (please contact us on Friday for Monday appointments). Receiving cancellation information in advance allows us to schedule and serve other patients. We reserve the right to bill you $50 for missed appointments without a 24-hour advance notice of any appointment change or reschedule. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay before your next visit.

Our physicians may charge for completion of forms, for which they may request a pre-payment at the time the form is received.

Our fees are available upon request.

Please contact us at (763) 588-0661, Monday through Friday, from 8:00 am - 5:00 pm, if you have questions. Thank you.

Minneapolis Clinic of Neurology

REHABILITATION SERVICES

APPOINTMENT POLICY

We strive to provide a high quality service in a caring and cost effective manner. This requires a commitment on your part; therefore, we request that you abide by the following courtesies:

1) You agree to make every effort to arrive on time for all appointments. If you are more than 10 minutes late for your appointment, you may be asked to reschedule.

2) We reserve specific appointment times for you (depending on your needs). If you need to cancel your appointment, you agree to give at least 24 hours notice whenever possible. **You may also be charged a $50 fee for late cancels or no shows.**

3) You understand that all of your remaining appointments may be cancelled if you have missed two appointments and failed to give appropriate notice as outlined above. If this occurs and you want to return to therapy, you will need to contact your physician. **If you have not initiated your therapy appointments within 30 days from when the order was written, it is your responsibility to obtain a new order from your doctor.**

4) You agree to pay your co-pay for each visit at the time of each service.

5) **If your appointment is for low back pain, please bring a pair of shorts.**

I have read and understand this policy and agree to make this commitment.

_____ _____

SIGNATURE DATE

NO INSURANCE/NO REFERRAL WAIVER

Coverage for services varies among insurance plans. Please refer to your insurance manual to determine what coverage you have for physical therapy services and whether a referral is necessary. We will bill your insurance company. If they deny payment for lack of referral, we will bill you directly for these charges and payment will become your responsibility.

I have read and understand this referral policy and agree to accept the financial responsibility for treatments I receive.

_____ _____

SIGNATURE DATE

I am aware of my diagnosis and consent to receive physical therapy.

_____ _____

SIGNATURE DATE

P:GVPT/order form/4 GV/welcome/appointment policy 6/09

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Minneapolis Clinic of Neurology

REHABILITATION SERVICES

HEALTH INSURANCE BENEFITS WORKSHEET

We suggest that you contact your insurance company before starting our Rehabilitation Services program to determine the extent of your coverage for these services. Please bring this form with you to your first appointment. Thank you.

Questions to ask your insurance carrier before your first appointment:

My primary insurance is _____

My secondary insurance is _____

Does my insurance plan:

- ❑ Include coverage for outpatient physical therapy services at MCN? _____
- ❑ Cover only a limited dollar amount per calendar year (for example, a maximum of $700 a year?)_____
- ❑ Cover only a limited number of sessions for each calendar year? If Yes, how many? _____
- ❑ Cover only a certain amount and/or percentage of the bill for each visit? If Yes, what is the amount or percent covered? _____
- ❑ Require a deductible for the calendar year before coverage begins? If Yes, what is the dollar amount?_____

Am I required to:

- ❑ Pay a co-payment for physical therapy?_____. Please note that co-payments are due at time of service.
- ❑ Obtain prior authorization and/or referral from my primary physician before I see a physical therapist?_____ If Yes, bring the referral to your physical therapy appointment.

Are there any other restrictions?

_____

_____

I have verified the information above and understand that I am responsible for any charges that my insurance plan does not cover.

P/GVPT/order forms/4 gv/welcome/insben 6/09

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MINNEAPOLIS CLINIC OF NEUROLOGY, LTD.
PHYSICAL THERAPY MEDICAL HISTORY/SUBJECTIVE INFORMATION
A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

YOUR NAME:				DATE:
DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:	ARE YOU PREGNANT? YES NO

Have you ever had any of the following? (Please circle yes or no)

	Self	Family		Self	Family
Tuberculosis	No Yes	No Yes	Epilepsy/Seizures	No Yes	No Yes
Diabetes	No Yes	No Yes	Arthritis	No Yes	No Yes
Heart Condition	No Yes	No Yes	Stroke	No Yes	No Yes
Cancer	No Yes	No Yes	Respiratory Problems	No Yes	No Yes
Hepatitis	No Yes	No Yes	Migraines	No Yes	No Yes
High Blood Pressure	No Yes	No Yes	AIDS/Infectious Diseases	No Yes	No Yes
High Cholesterol	No Yes	No Yes	Other:	No Yes	No Yes

What are your current symptoms?_____

_____

_____

Frequency?_____

_____

_____

When did you first notice your symptoms or have functional problems due to the condition/injury?
First Episode:_____
Most Recent:_____
How did your symptoms/injury occur?_____

_____

_____

_____

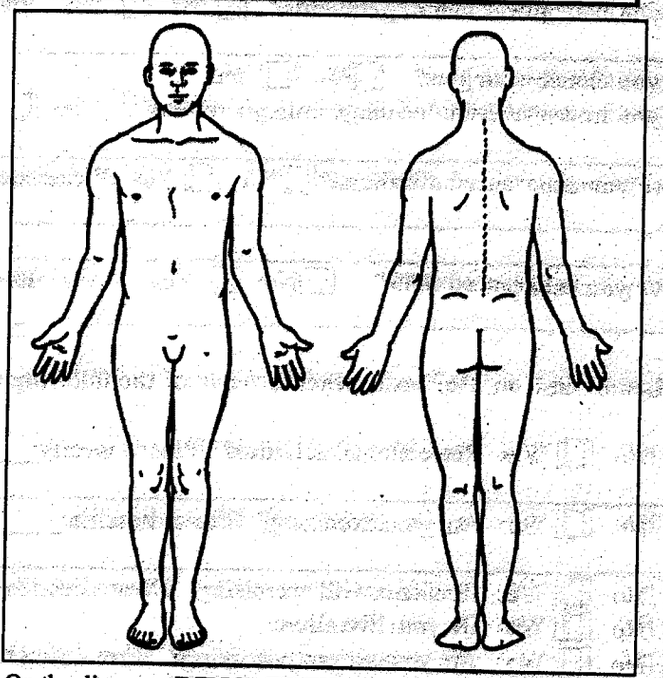
Using a 0-10 pain/symptoms scale (0 = none; 10 = extreme)
Grade your pain/symptoms:
Typical past week_____ Today's_____
What makes your symptoms better?_____

_____

_____

Worse?_____

_____



On the diagram, INDICATE THE AREAS of your symptoms

Have you had any surgery or previous injuries? ☐ No ☐ Yes
What kind and for what condition?_____

_____

Have you received any injections for your injury/condition? ☐ No ☐ Yes If yes, when?_____
Did it help? ☐ No ☐ Yes **If yes, how?**_____
Current medications:_____

_____

Diagnostic Tests Performed:_____

_____

Does coughing or sneezing affect your back? ☐ No ☐ Yes
Do you have bowel or bladder problems? (Frequency, Urgency, Unable to Void) ☐ No ☐ Yes

OVER

Please fill out both sides before your appointment

Date:	Name:	DOB:

For your current condition/injury have you seen any of the following?

	From	To		From	To
Medical Doctor			Physical Therapist		
Psychiatrist/Psychologist			Chiropractor		

Do you get headaches? ☐ No ☐ Yes
Location _____
I have headaches _____ **% of the time or** _____ **days per week or month(circle) Intensity** (0-10)_____
Do you use caffeine? ☐ No ☐ Yes **Do you sleep on your stomach?** ☐ No ☐ Yes
Do you have jaw or dental problems? ☐ No ☐ Yes **Please describe:** _____
_____
Do you clench your jaw? ☐ No ☐ Yes
Do you have eye/vision/hearing/sinus problems? ☐ No ☐ Yes **Please describe:** _____
_____
Have you experienced dizziness? ☐ No ☐ Yes **Please specify movements or activities that cause this dizziness:**
_____
_____
Have you experienced falls? ☐ No ☐ Yes **Please describe:** _____
_____

Indicate "Yes" or "No" as to whether each of the following activities are difficult:

☐ No ☐ Yes Recreational activities? Please specify: _____
_____
☐ No ☐ Yes Are you exercising? Please describe _____
_____
☐ No ☐ Yes Problems with exercising: Please describe _____
☐ No ☐ Yes Do you live alone
☐ No ☐ Yes Are you currently working? How many hours? _____ Job Title _____
☐ No ☐ Yes Are you having problems performing your job? Please explain: _____
_____
☐ No ☐ Yes Other: _____
What do you hope to accomplish with treatment? _____

Date:	Name:	DOB:

Goals/Justification for Therapy

Please fill out *LEFT column ONLY* before first Physical Therapy Appointment	***RIGHT* column to be filled out by *Physical Therapist ONLY***	**# of weeks**
Indicate with an X in box if activity is affected by your current symptoms.	☐In-clinic (short-term goal)/☐Post-therapy (long-term goal)	
Self-Management of Symptoms		
☐Difficulty self-managing symptoms	☐/☐ Understands and is compliant in self-management program for improved function and ongoing management	
Transfer Disability		
☐Difficulty getting in and out of ☐Chairs ☐Bed ☐Car ☐Bath/Shower	☐/☐ Able to get in and out of ☐Chairs ☐Bed ☐Car ☐Bath/Shower	
Dressing Disability		
☐Difficulty putting on/taking off shoes, pants, skirts, jackets	☐/☐ Improved ability to dress self Including:	
Sleep Impairments		
☐Awakens _____ times per night secondary to symptoms	☐/☐ Awakens less than _____ times per night secondary to symptoms	
Reaching Disability		
☐Difficulty reaching ☐forward ☐overhead ☐behind back ☐downward	☐/☐ Able to reach	
Endurance Disability		
☐Difficulty with prolonged sitting greater than ____ minutes ☐Difficulty with prolonged standing greater than _____ minutes ☐Difficulty with static neck flexion	☐/☐ Able to prolonged sit for _____ minutes ☐/☐ Able to prolonged stand for _____ minutes ☐/☐ Able to maintain static neck flexion for _____	
Ambulation Disability		
☐Difficulty walking greater than ____ minutes or greater than _____(distance) ☐Difficulty ascending/descending stairs	☐/☐ Able to walk for _____minutes ☐/☐ Able to ascend/descend stairs	
Transport Difficulty		
☐Difficulty turning neck to view traffic	☐/☐ Able to turn neck to view traffic	
Manual Activity Disability		
☐Difficulty gripping/holding objects, writing	☐/☐ Improved ability to grip/hold objects, write	
Lifting Disability		
☐Difficulty lifting or carrying	☐/☐ Able to lift or carry	
Household Disability		
☐Difficulty performing housework/yard work such as:	☐/☐ Able to perform housework/yard work such as:	
Recreational Disability		
☐Difficulty participating in recreational activities	☐/☐ Able to participate in recreational activities	
Occupation Handicap		
☐_____ ☐_____ ☐_____	☐/☐ _____ ☐/☐ _____ ☐/☐ _____	
Pain Levels – Pain Rating		
☐_____/10 (0=no pain, 10=severe pain)	☐/☐ Improve pain rating to _____/10	
Headaches		
☐Frequency _____ times per week	☐/☐ Decrease headache frequency to _____ times per week	
☐	☐/☐	
☐	☐/☐	
☐	☐/☐	