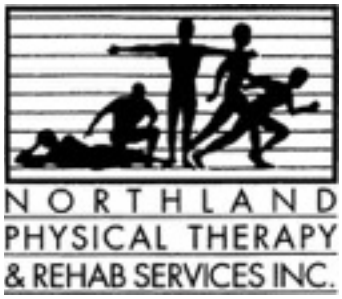

NORTHLAND PHYSICAL THERAPY & REHAB SERVICES, INC.

☐ **North Kansas City**
2100 Swift
North Kansas City, MO
64116
Ofc (816) 474-8877
Fax (816) 474-8878

☐ **I-29/Barry Road**
5903 NW Barry Road
Kansas City, MO
64151
Ofc (816) 741-5540
Fax (816) 741-9720

☐ **Liberty**
9151 NE 81st Terrace
Kansas City, MO
64158
Ofc (816) 415-4971
Fax (816) 415-8270

WELCOME TO NORTHLAND PHYSICAL THERAPY

We sincerely thank you for choosing Northland Physical Therapy as your provider for rehabilitation services. As the most established outpatient physical therapy clinic in the city, with nearly 40 years serving in the Northland, you have our pledge that we will provide the best possible care to you and/or your loved ones.

The following items may assist you as you receive our services or consider scheduling your visit:

1. We will try very hard to maintain a consistency with a team of physical therapists and physical therapy assistants that you see. However, staff illness, vacations, seminar attendance, or even your own scheduling conflicts may warrant a time slot where you will be treated by another staff member. Rest assured that precise documentation of each visit is made so that all staff are well aware of your condition, as well as your previous treatments, goals, etc.
2. We strongly believe that a consistent progression in your condition is in part due to the Home Exercise Program provided to you by your therapist or assistant. You will frequently be instructed on detailed techniques, positions, and exercises to be performed at home, and it is paramount that you complete these at the requested frequency.
3. Northland Physical Therapy has been selected as a teaching facility for several physical therapists and physical therapy assistant programs, including Rockhurst College, Kansas University, Missouri University, and Penn Valley Community College. From time to time you may have a student assist in the care of your injury; however, this will always be under the supervision of one of our staff members.
4. Cancellations and No-Shows: Your therapist will recommend a special treatment plan, including a specific number of treatments per week. Attending all of these visits is crucial to your rehabilitation. Missing these appointments will only slow your recovery. Appointment no-shows or last-minute cancellations will not only hinder your recovery but will also negatively impact other patients looking for convenient appointment times. We will make every effort to be as flexible as possible in scheduling appointment times that are most convenient for you. Please return this courtesy by attending all scheduled appointments. A $25 charge will be assessed for no-shows or cancellations without 24-hour notice of your scheduled appointment time. For those patients unable to attend a scheduled Monday appointment, our office must be notified by 3:30 p.m. the previous Friday.

I want to personally guarantee that you will receive the best possible experience and physical therapy services at Northland Physical Therapy. If any problems should arise with any aspect of your care, I strongly encourage you to contact our Practice Manager or myself, at (816) 474-8877.

Sincerely,

Frank J. Ferrantelle, P.T.

_____ _____
Patient Signature Date

NORTHLAND PHYSICAL THERAPY AND REHAB. SERVICES INC. **ACCOUNT #** _____

THERAPIST _____ OFFICE _____ (OFFICE USE ONLY)

PATIENT INFORMATION ** **Please print and complete all information** ** DATE: _____

NAME _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

HOME PHONE _____ **CELL PHONE** _____ **WORK** _____

DATE OF BIRTH _____/_____/_____ **SOCIAL SECURITY NUMBER** _____/_____/_____ **GENDER** MALE FEMALE

E-MAIL ADDRESS: _____

MARITAL STATUS: SINGLE MARRIED LEGALLY SEPERATED DIVORCED WIDOWED OTHER

EMPLOYMENT STATUS: **(Please mark all that apply)** FULL TIME ____ PART TIME ____ NOT EMPLOYED ____ SELF EMPLOYED _____

RETIRED ____ ACTIVE DUTY ____ FULL TIME STUDENT____ PART TIME STUDENT _____

EMPLOYER_____

ADDRESS _____ CITY _____ STATE _____ZIP _____

OCCUPATION _____

PRIMARY CARE PHYSICIAN _____ PCP PHONE _____

NAME OF REFERING PHYSICIAN _____ REF PHY PH _____

DO YOU (PATIENT) HAVE A LIVING WILL (ADVANCED DIRECTIVE) YES _____ NO _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HAVE YOU BEEN A PATIENT HERE BEFORE _____ IF SO WHEN_____

** **RESPONSIBLE PARTY (If patient is under 18 years of age)** _____ RELATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ DATE OF BIRTH _____/_____/_____SOCIAL SERCURITY NUMBER _____/_____/_____

** **INSURANCE INFORMATION (Complete entire section and provide a copy of your insurance card(s).**

PRIMARY INSURANCE POLICY _____ I HAVE NO INSURANCE _____

SUBSCRIBERS NAME _____ SUBSCIBERS SS# _____/_____/_____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE PARENT OTHER **SUBSCRIBERS DOB #** _____/_____/_____

SECONDARY INSURANCE POLICY _____ I HAVE NO OTHER INS _____

SUBSCRIBERS NAME _____ SUBSCIBERS SS# _____/_____/_____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE PARENT OTHER **SUBSCRIBERS DOB #** _____/_____/_____

PLEASE CONTINUE TO NEXT PAGE_

IS THIS A WORK OR AUTO ACCIDENT RELATED INJURY YES NO WORK_____ AUTO _____

IF SO WHAT WAS YOUR DATE OF INJURY _____

IF YOUR SERVICES ARE GOING THROUGH YOUR WORKMANS COMP OR AUTO INSURANCE PLEASE FILL OUT THE FOLLOWING INFORMATION_____

CARRIER NAME: _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ CASE MANAGER OR ADJUSTORS NAME _____

CLAIM # _____ IF WORK COMP, HAS YOUR THERAPY BEEN AUTHORIZED _____

ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE NORTHLAND PHYSICAL THERAPY & REHAB SERVICES, INC TO FILE INSURANCE AND ASSIGN BENEFITS DIRECTLY PAYABLE, TO NPTRS INC. I AUTHORIZE NPTRS TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR PROCESSING FOR FINANCIAL BENEFITS. I ALSO CONSENT TO RELEASE OF MY MEDICAL RECORDS BY NPTRS FOR THE PURPOSE OF REVIEW OR AUDITS TO INSURANCE COMPANY, ADJUSTORS, OR MY ATTORNEY INVOLVED WITH THIS CASE. A PHOTOCOPY OF THE MENTIONED SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL. I UNDERSTAND INSURANCE CLAIMS ARE FILED AS A COURTESY. ALL BALANCES ARE MY RESPONSIBLITY. CO-PAYS AND CO-INSURANCES ARE DUE AT THE TIME OF SERVICES. FAILURE TO FULFILL MY FINANCIAL OBLIGATION WILL RESULT IN MY ACCOUNT BEING FORWARDED TO AN OUTSIDE COLLECTION AGENCY, WHICH WILL RESULT IN AN ADDITIONAL $50.00 SERVICE FEE CHARGE. DELINQUENT ACCOUNTS WILL BE REPORTED TO THE CREDIT BUREAU. I ALSO UNDERSTAND A FEE OF $30.00 WILL BE CHARGED FOR INSUFFICIENT CHECKS.
** NOT ALL SERCIVES ARE COVERED BY DIFFERENT INSURACE PLANS. IF YOU HAVE A QUESTION REGARDING BENEFITS **YOU** WILL HAVE TO CONTACT YOUR INSURANCE CARRIER. OUR OFFICE CANNOT AID IN DISPUTES REGARDING YOUR COVERAGE. I HEREBY AUTHORIZE NORTHLAND PHYSICAL THERAPY & REHAB SERVICES, INC. (N.P.T.R.S.) TO CARRY OUT ALL PROCEDURES AS ORDERED BY MY PHYSICIAN.

PATIENT SIGNATURE _____ DATE _____

IF YOU ARE OVER 18 YOU ARE RESPONSIBLE FOR CHARGES INCURRED.

RESPONSIBLE PARTY _____ DATE _____

*** PRIVACY NOTICE ***

I ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF NORTHLAND PHYSICAL THERAPY, INC. PRIVACY POLICY.

PATIENT SIGNATURE _____ DATE _____

*** MINOR TREATMENT AUTHORIZATION ***

I GIVE NPTRS AUTHORIZATION TO TREAT _____. I, FURTHER AUTHORIZE NPTRS TO TREAT THE MENTIONED PERSON WITHOUT MY PRESENCE.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PLEASE CONTINUE TO NEXT PAGE

I give permission for Northland Physical Therapy & Rehab Services, Inc. to leave information regarding my care in the following manner. I understand that I may revoke this consent at any time by giving a written notice to Northland Physical Therapy & Rehab Services, Inc.

Leave information for me at Phone #:_____

Or Phone #: _____. You may leave a message on my answering Machine YES_____ NO_____

Leave information to designated as listed below:

		All	Medical	Financial
Name: _____	Phone: _____	___	____	____
Name: _____	Phone: _____	___	____	____
Name: _____	Phone: _____	___	____	____

In case of Emergency

Name: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

NORTHLAND PHYSICAL THERAPY AND REHAB SERVICES, INC.

MEDICAL HISTORY

ALL QUESTIONS MUST BE ANSWERED

WHY ARE YOU COMING TO PHYSICAL THERAPY?

_____

_____

_____

IF AN INJURY, BE SPECIFIC ABOUT TIME/DATE AND HOW IT OCCURRED

_____

_____

_____

WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY (ie; less pain, improved mobility, increased strength, better sports performance, etc.)? _____

_____

_____

PAST MEDICAL INFORMATION

PLEASE CIRCLE IF YOU HAVE HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS

Allergies		Dizzy spells		Mental implants	
Anemia		Emphysema/Bronchitis		MRSA	
Anxiety		Fibromyalgia		Multiple Sclerosis	
Arthritis		Fractures		Muscular disease	
Asthma		Gallbladder problems		Osteoporosis	
Autoimmune Disorder		Headaches		Parkinson’s	
Cancer		Hearing Impairment		Rheumatoid arthritis	
Cardiac conditions				Seizures	
Cardiac Pacemaker		Hepatitis		Smoking	

Chemical dependency		High Cholesterol		Speech Problems	
Circulation problems		High/low blood pressure		Strokes	
Currently pregnant		HIV/AIDS		Thyroid disease	
Depression		Incontinence		Tuberculosis	
Diabetes		Kidney problems		Vision problems	

PLEASE EXPLAIN IF YOU HAVE CIRCLED ANY OF THE ABOVE OR IF THERE ARE ANY OTHER HEALTH-RELATED PROBLEMS THAT SHOULD BE BROUGHT TO OUR ATTENTION

_____

_____

_____

SURGICAL HISTORY- PLEASE LIST BODY REGION, TYPE OF SURGERY AND DATE:

_____

_____

_____

Current Medications- please list any current medications or provide us with a copy of your medication list:

Medication	Dosage	Frequency	Route (oral, injection, inhaled)	Reason

NORTHLAND PHYSICAL THERAPY & REHAB SERVICES INC.

Privacy Notice

Effective 04-15-03

To our Patients:

This notice reviews our policies and procedures regarding maintenance and disclosure of your personal information not available to the public.
Please read it carefully. We want you to understand that we may disclose or reserve the right to Disclose information described below to our affiliates and to third parties that are not affiliated With us (if permitted by law).

How we protect information: Except as explained below, we restrict access of your nonpublic Personal information to our employees, affiliates, or contracted entities that need to know in Order to provide our products and services to you. We maintain physical, electronic, and Procedural safeguards that comply with legal requirements to guard you non public personal Information.

Information we collect and maintain: We collect nonpublic personal information about you From the following sources: 1) information we receive from you on our patient information form: 2) Information from your physician's office, insurance companies 3) information from other Providers or agents.

Categories of information we may disclose: We may disclose or reserve the right to disclose The following categories of the nonpublic personal information we collect and maintain about You, including: 1) your name, address, social security number, financial information and similar Data we obtain form you on forms: 2) your policy coverage including eligibility data, co-Insurance benefits, benefits for therapy: 3) your medical condition as relates to your care with us From your physician.

Companies to whom we may disclose information: We may disclose or reserve the right to Disclose the categories of your nonpublic personal information described above, which we collect Or maintain about you, to our affiliates and to non affiliated third parties in the following types of Business including: 1) insurance and other financial service providers, such as affiliated or non Affiliated insurers, third party administrators, automobile liability insurers, workers Compensation insurers: 2) non-financial companies, such as affiliated or non affiliated healthcare Providers and their office and/or staffs, employers, auditors, attorneys and consultants. We may Also disclose and reserve the right to disclose any of you nonpublic personal information to our Affiliated and non affiliated third parties as permitted or required by law.

Companies that provide services for us: We may disclose or reserve the right to disclose the Categories of non affiliated third parties with which we contract to perform functions or services, Such as administrative services, on our behalf, and of financial institutions on our behalf.

Communicating with us: questions or comments about this Privacy Notice may be directed to:

Send written request/message to us at;
Northland Physical Therapy & Rehab Services Inc.
Attn: Privacy Department
2100 Swift
Kansas City, MO 64116