





For Office use only:

resting HR: \_\_\_\_\_

resting BP: \_\_\_\_\_

### Patient Medical History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are you seeking physical/occupational therapy for?(example: knee injury) \_\_\_\_\_

Is this a result of an injury that you had at work?      No      Yes

What date did you start to have problems? \_\_\_\_\_

What were you doing when this problem started? \_\_\_\_\_

Have you seen a doctor?      No      Yes      Who? \_\_\_\_\_

What type of tests have you had?(circle)      Xray      MRI      CT Scan      Blood Work  
Other (please describe) \_\_\_\_\_

Have you had any other treatments for this? (circle)      Ice      Heat      Rest  
Medicine(what kind) \_\_\_\_\_      Chiropractor      Massage therapy  
Therapy (where) \_\_\_\_\_

Do you have any of these health problems right now? (circle)      Cancer      Diabetes  
High Blood Pressure      Pregnant      Asthma      Shingles  
Arthritis(type and where) \_\_\_\_\_      HIV      Hepatitis

Have you ever had any of these health problems? (circle)      Cancer      Diabetes  
High Blood Pressure      Asthma      Hepatitis  
Broken bone (where and when) \_\_\_\_\_  
Surgery (for what and when) \_\_\_\_\_

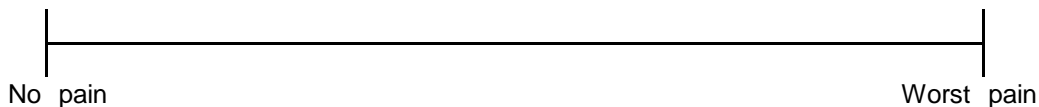
Are you having pain?      No      Yes

If so, where? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Please mark on the line below, where your pain is at right now.





**Motor Vehicle Accident and Personal Injury  
Insurance Form  
Supplement to Registration Form**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of other party involved \_\_\_\_\_

MVA? Y or N                      Personal Injury? Y or N                      Work Comp? Y or N

**Name of their insurance company:** \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of insured: \_\_\_\_\_ Claim Number \_\_\_\_\_

Address: Street \_\_\_\_\_ PO Box \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Attorney Name** \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: Street \_\_\_\_\_ PO Box \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER**

Insurance Company/Companies Name(s) \_\_\_\_\_

**I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to:**

**North Iowa Physical Therapy, LLC  
PO Box 185  
Buffalo Center, IA 50424**

for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I also agree to pay interest on any balance past 90 days. I understand that North Iowa Physical Therapy complies with HIPAA and will protect my PHI and will use it as allowable by law in the Treatment, Billing & Collections pertaining to my care until my case is closed and full payment received. **Complete HIPAA policy available in waiting room binder and upon request.** I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. This authorization is in effect until 90 days from the date the last bill is collected.

**A photo copy of this Assignment shall be considered effective and valid as the original.**

\_\_\_\_\_  
Patient Signature                      Date

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Parent or Guardian Name Printed



North Iowa Physical Therapy  
125 N Main Street  
PO Box 185  
Buffalo Center, IA 50424

## Patient Consent Form - HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to North Iowa Physical Therapy or by reviewing the current copy in our waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

\_\_\_\_\_  
Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Optional: Please restrict access to my personal health information (PHI) from:

\_\_\_\_\_  
Name Address Phone Number

\_\_\_\_\_  
Name Address Phone Number