

# Major Medical



Rice Lake/Turtle Lake/Spooner  
Physical Therapy

## Status

Please Circle One

**N.P.**      **R.T.N.P**

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Provider:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ S.S.#: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Dr. : \_\_\_\_\_ Primary Care Dr. : \_\_\_\_\_

Reason For Therapy: \_\_\_\_\_ Was Surgery Involved: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

### Medicare Patients

Have you rec'd any PT/OT/Speech this year? \_\_\_\_\_ If so, Where? \_\_\_\_\_  
Ph # \_\_\_\_\_

## Insurance Information

### Primary Insurance

Insurance Co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Employer: \_\_\_\_\_ D.O.B \_\_\_\_\_

I.D./Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Secondary Insurance

Insurance Co.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Employer: \_\_\_\_\_ D.O.B \_\_\_\_\_

I.D./Claim #: \_\_\_\_\_ Group #: \_\_\_\_\_



**Rice Lake  
Physical Therapy  
& Rehab Specialists**

Rice Lake • Turtle Lake • Spooner

Clinic: TLPTRS     NP     RTNP    Date:                      Time:                      Provider: EM

**Patient Personal Information**

Last Name:                      First Name:                      M.I.:                      Gender:     male     female

Address:                      City:                      State:                      Zip:

Phone #:                      SS#:                      DOB:                      Marital Status:                      E-Mail:

Referring MD:                      Phone #:                      PCP:

Employer:                      Occupation:                      Phone #:

Emergency Contact:                      Phone #:                      Relationship:

Reason for PT/OT:                      2<sup>nd</sup> Body Part:                      New Dx:                      DME visit only:

Injury Type:     WC     MVA     Other:                      Date of Injury:                      Surgery?

**Primary Insurance**

Ins. Company:                      Phone#:                      Ext:

Policy Holder:                      Employer:                      Phone #:                      DOB:

ID/Claim #:                      Group/Site #:                      Effective Date:

**Secondary Insurance**

Ins. Company:                      Phone #:                      Ext:

Policy Holder:                      Employer:                      Phone #:                      DOB:

ID/Claim #:                      Group/Site #:                      Effective Date:

**MVA Insurance**

Ins. Company:                      Adjuster:                      Phone#:                      Ext:

Policy Holder:                      DOB:

Policy/Claim #:                      Date of Injury:

Attorney:                      Phone #:

**Work Comp Insurance**

WC Employer:

Contact:                      Phone#:

Employer Address:                      City:                      State:                      Zip:

Ins. Company:                      Adjuster:                      Phone#:                      Ext:

Policy/Claim #:                      Date of Injury:

How did you hear about us?





## OPTIMAL INSTRUMENT Demographic Information

1. Date of Birth \_\_\_\_\_  
mm / dd / yyyy
2. Sex
  - 1) \_\_\_ Male
  - 2) \_\_\_ Female
3. Race
  - 1) \_\_\_ Aleut/Eskimo
  - 2) \_\_\_ American Indian
  - 3) \_\_\_ Asian/Pacific Islander
  - 4) \_\_\_ Black
  - 5) \_\_\_ White
  - 6) \_\_\_ Other
4. Ethnicity
  - 1) \_\_\_ Hispanic or Latino
  - 2) \_\_\_ Not Hispanic or Latino
5. Insurance (Please check all that apply)
  - 1) \_\_\_ Workers' compensation
  - 2) \_\_\_ Self-pay
  - 3) \_\_\_ HMO/PPO/private insurance
  - 4) \_\_\_ Medicare
  - 5) \_\_\_ Medicaid
  - 6) \_\_\_ Auto
  - 7) \_\_\_ Other
6. Education (Please check one)
  - 1) \_\_\_ Less than high school
  - 2) \_\_\_ Some high school
  - 3) \_\_\_ High school graduate
  - 4) \_\_\_ Attended or graduated from technical school
  - 5) \_\_\_ Attended college, did not graduate
  - 6) \_\_\_ College graduate
  - 7) \_\_\_ Completed graduate school/advanced degree
7. Please check the combined annual income of everyone in your house:
  - 1) \_\_\_ Less than \$10,000
  - 2) \_\_\_ \$10,000–\$14,999
  - 3) \_\_\_ \$15,000–\$24,999
  - 4) \_\_\_ \$25,000–\$34,999
  - 5) \_\_\_ \$35,000–\$49,999
  - 6) \_\_\_ \$50,000–\$74,999
  - 7) \_\_\_ \$75,000–\$99,999
  - 8) \_\_\_ \$100,000–\$149,999
  - 9) \_\_\_ \$150,000 or more
8. Employment/Work (Check all that apply)
  - 1) \_\_\_ Working full-time outside of home
  - 2) \_\_\_ Working part-time outside of home
  - 3) \_\_\_ Working full-time from home
  - 4) \_\_\_ Working part-time from home
  - 5) \_\_\_ Working with modification in job because of current illness/injury
  - 6) \_\_\_ Not working because of current illness/injury
  - 7) \_\_\_ Homemaker
  - 8) \_\_\_ Student
  - 9) \_\_\_ Retired
  - 10) \_\_\_ UnemployedOccupation: \_\_\_\_\_
9. Do you use a: (Check all that apply)
  - 1) \_\_\_ Cane?
  - 2) \_\_\_ Walker, rolling walker, or rollator?
  - 3) \_\_\_ Manual wheelchair?
  - 4) \_\_\_ Motorized wheelchair?
  - 5) \_\_\_ Other: \_\_\_\_\_
10. With whom do you live? (Check all that apply)
  - 1) \_\_\_ Alone
  - 2) \_\_\_ Spouse/significant other
  - 3) \_\_\_ Child/children
  - 4) \_\_\_ Other relative(s)
  - 5) \_\_\_ Group setting
  - 6) \_\_\_ Personal care attendant
  - 7) \_\_\_ Other: \_\_\_\_\_
11. Where do you live?
  - 1) \_\_\_ Private home
  - 2) \_\_\_ Private apartment
  - 3) \_\_\_ Rented room
  - 4) \_\_\_ Board and care/assisted living/group home
  - 5) \_\_\_ Homeless (with or without shelter)
  - 6) \_\_\_ Long-term care facility (nursing home)
  - 7) \_\_\_ Hospice
  - 8) \_\_\_ Other

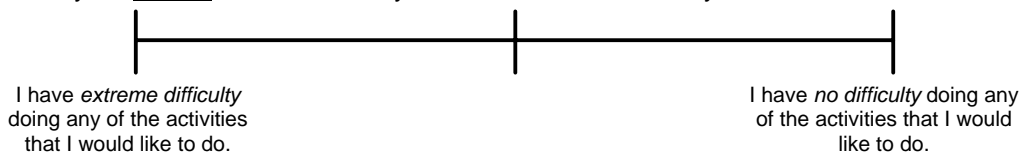
Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515–530.

# OPTIMAL INSTRUMENT

## Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.







Rice Lake/Turtle Lake/Spooner  
Physical Therapy

***Release of Medical Records-***

I hereby authorize **Rice Lake Physical Therapy and Rehab Specialists** to furnish information to insurance carriers concerning illness or accident and treatment, and I hereby assign to Rehab Management Solutions all payments for Medical services rendered to me or my dependants. I also authorize the release of my medical records to the agents of **Rice Lake Physical Therapy and Rehab Specialists** and/or agents so indicated by myself.

***Consent to Treat-***

I give permission/authorization for treatment of services performed by **Rice Lake Physical Therapy and Rehab Specialists** rendered to myself or dependant.

The above listed information as provided by \_\_\_\_\_ and my insurance carrier, I believe to be true and correct. I agree to the terms and conditions of payment fees for services and treatment as presented in this document:

***Consent to Treat-***

As a customer service to you, **Rice Lake Physical Therapy and Rehab Specialists** verifies benefits prior to your first visit. However, we did not receive all of your information at the time of registration; any services rendered will be your financial responsibility until the information is obtained.

***Signed:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

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# SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

**Rice Lake Physical Therapy & Rehab Specialists**

**Effective Date: August 19, 2003**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Connie Ziccarelli, COO/Managed Care Operations at 877-552-2996.

**WHO WILL FOLLOW THIS NOTICE:**

- Rice Lake Physical Therapy & Rehab Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

**OUR PLEDGE REGARDING HEALTH INFORMATION:**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**

- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

#### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.**

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Connie Zicarelli, COO/Managed Care Operations at 877-552-2996.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Connie Zicarelli, COO/Managed Care Operations at 877-552-2996. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### **OTHER USES OF HEALTH INFORMATION.**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



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### Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Turtle Lake Physical Therapy & Rehab Specialists.

X **Date:** \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Turtle Lake Physical Therapy & Rehab Specialists, state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

X **Date:** \_\_\_\_\_