Arrival Policy

700 N Monroe, Minneota, MN 56264
(p) 507.872.5308 (f) 507.872.5325

In order to receive the maximum benefit from your rehabilitation program, it is important to understand and comply with the following guidelines:

- *Attend all scheduled therapy appointments and follow any home instructions.*
- *Notify the clinic 24 hours prior to your scheduled appointment if you are unable to attend*
- *Inform the front desk staff of upcoming physician appointments or any other scheduling conflicts*
- *In addition, patients may be subject to discharge from therapy services when they fail to arrive to three scheduled appointments.*
- *At times it may be necessary for Big Stone Therapies, Inc. to change or reschedule your therapy appointment(s). By signing this agreement I give consent to allow the staff at Big Stone Therapies, Inc. to contact me by phone, email, at home or work regarding information about my therapy appointment(s) including leaving messages.*

Your compliance with this policy will ensure that we can provide you with the best therapy experience. We look forward to the opportunity to work with you and to help you heal.

I understand and agree to the following policy as stated above.

_____ _____

Patient Signature Date

We will be communicating with your physician throughout the course of your treatment to keep him/her well informed of your treatment plan and your progress. We take pride in keeping a high level of communication with your health care provider to ensure the highest quality of care.

Patient Intake Form

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I. PATIENT INFORMATION

Date_____ Referring Doctor_____

How did you hear about us? /How did you find us? /Who referred you to us? _____

Last Name_____First_____M.I._____

Address_____Apt#_____

City_____ State_____ Zip Code_____

Phone Number_____ Cell Number_____ Date of Birth_____

Sex M_____ F_____ SS#_____ Medicare#_____

Marital Status M_____ S_____ D_____ W_____ Contact Person_____

Contact Person Phone #_____ Relationship to contact person_____

Since January 1, have you been treated by a physical, occupational, or speech therapist? Yes No

Where_____

Are you entitled to benefits through the Department of Veterans Affairs? Yes___ No___

Are you entitled to benefits through TriCare? Yes___ No___

Are you currently receiving Home Health/Nursing/other Therapy Services or have you received Home Health/Nursing/other Therapy Services within the past 30 days? Yes___ No___ If yes, where? _____

If your Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer? I do not have Medicare coverage___Yes (Group insurance will be primary) ___ No (Medicare will be primary) ___

II. PRIMARY INSURANCE INFORMATION

Are you the primary cardholder? Yes____ No____ If no, who is? _____

Your relationship to the primary cardholder_____ Primary Card Holder's Date of Birth_____

Primary Card Holder's address (if different than address above) _____

Policy Number _____Group Number_____

Insurance Company Name_____

III. SECONDARY INSURANCE INFORMATION

Are you the primary cardholder? Yes____ No____ If no, who is? _____

Your relationship to the primary cardholder_____ Primary Card Holder's Date of Birth_____

Policy Number _____Group Number_____

Insurance Company Name_____

IV. WORK INFORMATION

Employer's Name_____

Employer's Address_____

City_____ State_____ Zip Code_____

Work Phone Number_____ Occupation_____

(Please see other side)

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V. INJURY INFORMATION

Date of Injury_____

Is this an auto accident related injury? Yes___ No___ (If yes, please complete section VI)

Is this a work related injury? Yes___ No___ (If yes, please complete section VII)

Is this an accident on property (other than your own) related injury? Yes___ No___ (If yes, please complete section VI)

Is there an attorney involved Yes___ No___ (If yes, please complete section VIII)

VI. AUTO OR OTHER INSURANCE INFORMATION

Name of Insured_____ State in which accident occurred_____

Auto Insurance Company Name_____

Address_____

City_____State_____Zip Code_____

Policy Number_____ Claim Number_____

Adjustor's Name_____ Phone#_____ Fax #_____

VII. WORKER'S COMPENSATION INFORMATION

Employers Name (at time of injury) _____

W/C Insurance Name_____

Address_____

City_____State_____Zip Code_____

Phone#_____ Fax #_____

Claim Number_____ Adjustor Name_____

VIII. ATTORNEY INFORMATION

Name_____ Phone #_____

Address_____

City_____State_____Zip Code_____

AUTHORIZATION TO PAY MINNEOTA MANOR

Consent to Treat/Assignment of Benefits

I hereby consent treatment and procedures considered necessary and ordered by the therapist. I hereby authorize my insurance benefits to be paid directly to MINNEOTA MANOR and I am financially responsible for non-covered services. I also authorize MINNEOTA MANOR. to release any information to process this claim.
Patient signature or guarantor if under 18.

SIGNED_____ DATE _____

OFFICE USE ONLY

KX Modifier Start Date_____

PT Diagnosis and Treatment Codes_____

OT Diagnosis and Treatment Codes_____

SLP Diagnosis and Treatment Codes_____

Medical History Form

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To better acquaint your therapist with your medical history, you have been asked to complete this health questionnaire. Your answers are strictly confidential and help your therapist perform a detailed evaluation.

Name _____ Height _____ Weight _____

Occupation _____ Full Time or Part Time (circle) Work Restrictions? Yes/No (circle)

What do you do for work activities? _____

What do you do for hobby/leisure/sports activities? _____

How would you rate your general health status? Excellent Good Fair Poor (circle one)

During the past month, have you been bothered by feeling down, depressed, or hopeless? Yes/No (circle)

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes/No (circle)

If yes, is this something with which you would like help? Yes/Yes, but not today/No (circle)

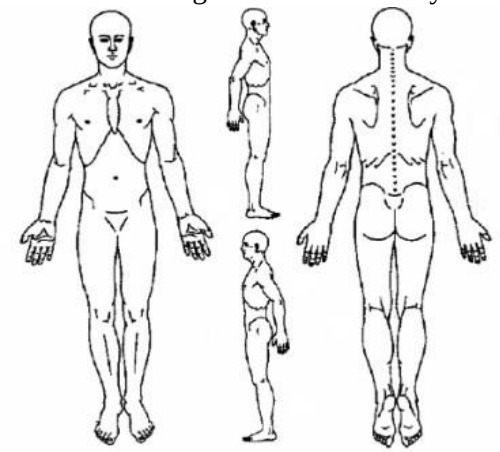
Do you smoke or use tobacco? Yes/No (circle) Do you drink alcohol? Yes/No (circle)

What is your stress level? Low Medium High (circle one)

Would you be interested in learning about a Wellness or weight loss program? Yes/No (circle)

----------Current Symptoms----------

Please mark the area on the diagrams below where your symptoms are:



Please circle the number which best represents the severity of your pain.

At **WORST** the last 24 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

At **BEST** the last 24 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

AVERAGE over the last 24 hours
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Briefly describe current symptoms _____

When and how (gradually or suddenly) did the symptoms start?_____

_____

Do your symptoms completely go away for any period to time? Yes / No (circle)

Are your symptoms worse at any time of the day? Yes / No (circle) If Yes, then when?_____

What makes your symptoms WORSE? (circle all that apply)

Lying down Standing Walking Stress Sitting Other: _____

What makes your symptoms BETTER? (circle all that apply)

Lying down Standing Walking Stress Sitting Other: _____

Currently are you receiving treatment from anyone else for your symptoms? Yes/No (circle)

If yes, please list _____

Have you previously received treatment for symptoms? Yes/No (circle)

Medical History Form

BIG STONE Therapies, Inc. "Rock Solid Rehab"
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If yes, when and what providers _____

Have you had an x-ray, MRI, or other imaging for this issue? Yes/No (circle)

If yes, please explain _____

Are the symptoms currently: Better Worse Same (circle one)

Medical History

Do you currently have, or have previously, been diagnosed with any of the following conditions? (circle all that apply)

Cancer	Heart Problems	Lung Problems	Neurologic Disorders	Diabetes
Osteoporosis	Poor Balance	Changes in Appetite	Dizziness/Vertigo	Arthritis
Headaches	Thyroid Disease	Nausea/Vomiting	Difficult swallowing	Peripheral Artery Disease
Unwanted Bowel or Bladder Loss		Loss of Consciousness	Sensitivity to Cold/Heat	Night Sweats

List all prescription and/or over the counter medications recently or currently taking. ☐ See attached prescription list.

_____

_____

Did you have any previous surgical history? (circle and date all that apply)

Hospitalizations _____	Broken Bones _____	Serious Illnesses _____	Falls _____
Surgeries _____	Dislocations _____	Sprains _____	Other _____

Do you have a family history of any of the following? (circle all that apply)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Arthritis/Osteoporosis	Stroke	Psychosocial Disorders	Peripheral Artery Disease

Other _____

Currently I am experiencing (circle all that apply)

Fever/Chills/Sweats	Poor Balance (Falls)	Unexplained Weight Loss	Numbness or Tingling
Changes in Appetite	Depression	Difficulty Swallowing	Recent Bacterial Infection
Shortness of Breath	Dizziness	Fatigue	Changes in Bowel or Bladder Function
Headaches	Nausea/Vomiting	Increased Pain at Night	Recent Trauma or Accidents
Numbness in area that covers a bicycle seat		Urine Retention	Morning Stiffness

Personal Information

Do you have any barriers to learning? Yes/No (circle)

If yes, please explain _____

What methods of learning do you prefer? (circle all that apply)

Handouts Demonstration Practice Verbal Instruction Written Instruction

Identify up to three important functional activities that you are currently unable to do or are having difficulty with:

1. _____
2. _____
3. _____

Please list personal goal(s) for therapy _____

Medical History Form

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Patient Signature _____ Date _____

Parent/Guardian signature if patient is under 18 years of age

Lower Extremity Functional Scale

Patient Name _____ Date _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of the bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into or out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking a mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14	Standing for 1 hour	0	1	2	3	4
15	Sitting for 1 hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points SCORE: _____ / 80

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.