Dr. Samantha Russell, OTR/L
2008 E. Northern Lights Blvd. Anchorage, AK 99508 Phone (907) 677-9216 Fax (907) 569-5078

Name:_________________________________ Birth date:_____________ SS#:______________
Last First Middle Initial

Address:____
City State Zip Code

Home Phone: (_____)-______________ Cell: (_____)-_____________ Work: (_____)-______________

Email Address:____________________ Employer Name:__________________ Phone:___________

Name of emergency contact:___________________________ Phone: (_____)-___________________

Which number may we call you at to confirm the appointments? HOME CELL WORK

Guarantor Information: If patient is a minor please fill in the following

Name: ____________________________________ Relationship to patient:__________________

Address: ____
Only if different than our patient

Employer Name:____________________________ Phone:_________________

In order to better serve you please list your primary doctor so that we can request pertinent health information.

Name of primary Doctor:_________________________ Phone:____________________________

Whom may we thank for referring you? (Circle one)

Anchorage Daily News — Professional (name)________________________ — PPO List
New Resident letter — Family (name)____________________________ — Walk-in/Sign
Yellow Page — Friend (name)____________________________ — Other____________

I authorize treatment for the patient named above. I understand that Core Kinetics Occupational Therapy and Physical Rehabilitation, LLC will assist me in billing my insurance carrier. I also understand and agree that a copy of my insurance card will be given to the clinic. I also understand that my insurance policy is an arrangement between the insurance carrier and me. I understand and agree I am ultimately responsible for the balance of my account for any professional services rendered (regardless of my insurance status). I certify this information is true and correct to the best of my knowledge. I will notify Core Kinetics Occupational Therapy and Physical Rehabilitation, LLC of any changes in my status or the above information.

Patient signature:______________________________ Date:_____________

Guarantor signature:____________________________ Date: _____________

Samantha Russell, OTR/L

FINANCIAL POLICY

Thank you for choosing Core Kinetics Occupational Therapy and Physical Rehabilitation, LLC. It is our commitment to make your occupational and physical therapy needs a success. To better serve your financial needs, our office offers several methods of payment. Please choose the plan that suits you. Patients who are here for their first visit are expected to pay in full unless prior arrangements have been made with the billing department. We are happy to answer any questions you have regarding our fees.

Please check one of the following plans:

______ **Cash/Check/Credit Card***: Fees are to be paid at the time services are rendered unless special arrangements have been made in advance.

______ **Workers' Compensation***: We will bill your employer's workers' compensation insurance company directly. We require all insurance information, including claim number, within 3 days after your first appointment.

______ **Auto Accident***: ***A co-pay of $10 is required for each visit and reimbursable once the claim has been settled.*** We are willing to work with your lawyer or bill the insurance company directly. You will need to provide all claim numbers and billing information within 3 days after your first appointment.

______ **Private Insurance***: As a courtesy to our patients, we will bill your insurance company once you have met your annual deductible. You are responsible for **co-payments** and for any **non-covered services** at the time of your visit.

- A 12% per annum will be applied to unpaid balances that are over 90 days.

Cancellation Policy

Appointments can be re-scheduled or cancelled free of charge if we are notified at least 12 hours before your scheduled appointment. Cancellations or missed appointments will be subject to a $20 administrative fee if the 12 hour notice was not given. Cancelled or missed massage therapy appointments will be subject to a $20 cancellation fee for 30 minute massages, $30 cancellation fee for 45 minute massages, and $40 cancellation fee for 60 minute massages. Insurance will not be billed for this charge.

Financial Agreement

* I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
* I have read the policies above and understand them.
* I understand I am financially responsible for all charges, whether or not they are covered by my insurance company.
* I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
* I authorize and request payment of medical benefits directly to my provider.
* I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
* I understand that charges may occasionally be added or modified by my clinician.
* I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date. Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I/we agree to pay reasonable attorney's fees or other such cost as the Court determines proper.

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

I understand and agree to this Financial & Cancellation Policy:

Patient Signature:_______________________________________ Date____________

Guarantor Signature _____________________________________ Date____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Core Kinetics Occupational Therapy and Physical Rehabilitation, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

__________________ Date

____________________________________ Signature

____________________________________ Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of ____________________ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

______ Patient Unavailable
______ Patient Physically Unable
______ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

______ Personally ______ Mail _____ Phone Follow Up

______ Other: ____

__________________ Date

____________________________________ Signature

____________________________________ Print Name of Physician

Core Kinetics Occupational Therapy and Physical Rehabilitation, LLC

Name of Practice

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, ___________________________ [Name of Individual] consent to Core Kinetics Occupational Therapy and Physical Rehabiliation, LLC's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

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Name:________________________________ **Application For Care**

1. Please describe the health problem, for which you are seeking care: ____

2. Were your symptoms: □ Were initiated by an injury □ Occurred gradually □ Occurred Suddenly □ Not initiated by injury

3. Have you ever had these symptoms before this episode? □ Y □ N, if yes, how many times in the past have you felt them. (That lasted at least one day, but went away completely) □ 1-5 times □ 6-10 times □ >10 times

4. Have your symptoms: □ Improved □ Worsen gradually □ Worsen quickly □ Stayed the same

5. Mark areas on the diagram at the right where you feel discomfort/symptoms:

6. When was the first time you felt these symptoms? ___________________

7. Are your symptoms worse in the: □ Morning □ Afternoon □ Night □ sleeping

8. Are your symptoms: □ <25% of the time □ 25%-50% □ 50% -90% □ 100%

9. Describe pain/sensations in the affected body parts and when it started (burning, tingling, numbness, pins & needles, sharp achy dull achy dull, etc.)

Head________ Neck ________ Shoulder ________ Back ________ Groin ____________ Arms ________________
Hands ___________ Leg(s) ___________ Foot/Feet ___________ Other _____________________________

10. Please mark the scale to show how bad your discomfort has been recently. Please mark more than one area, and rate each pain, if you have more than one symptom.

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst possible discomfort

11. Describe what makes your symptoms worse: ____

12. Describe what makes your symptoms better: ____

13. Have you had treatment for this condition before? □ Y □ N, if yes, please state when you were treated, the name of the practitioner, and the results attained. ____

14. Do you have any recent x-rays (within the last 12 months) □ Y □ N

15. Do you exercise regularly? Please describe ____

16. Do you smoke? □ Y □ N, if yes, how much _______ drink alcohol? □ Y □ N, If yes, how much and how often? ________________

17. Do you sleep poorly at night? □ Y □ N 2. Do you sleep on your stomach? □ Y □ N

18. Is your pain constant and significantly worse at night? □ Y □ N

Patient Goals: Please write down what you hope to achieve by becoming one of our patients. We have listed a few common ones

□ Get out of pain □ Work out with no pain □ Increase my range of motion □ Perform better in sports

Please list any other goals that are not listed above ____

Women Only

Are you or could you be pregnant? □ Y □ N 2. Are you still having menstrual periods? □ Y □ N, if yes, when was the first day of you last menstrual period? _________

Family Health History

1. Do you have any relatives with similar problems? □ Y □ N If yes explain: ________________________________
2. Is there family history of: □ Cancer □ Diabetes □ Stroke □ High Blood Pressure □ Other If yes, please explain:

____

Past History

Please write in the year/years in which you had any of the following **and** mark **X** if you currently have any:

☐ Anemia	☐ Diabetes	☐ Heart attack/Disease	☐ Mumps	☐ Gout
☐ Angina	☐ Digestive disorder	☐ Heartburn	☐ Pleurisy	☐ Mutlipe sclerosis
☐ Appendicitis	☐ Dizziness/Fainting	☐ Hepatitis	☐ Pneumonia	☐ Sinus problems
☐ Arteriosclerosis	☐ Double vision	☐ High blood pressure	☐ Polio	☐ Stoke
☐ Arthritis	☐ Sexual abuse	☐ HIV infection/positive	☐ Poor circulation	☐ Thyroid problem
☐ Asthma	☐ Depression	☐ Kidney stones/disease	☐ Prostate hypertrophy	☐ TMJ
☐ Back/Neck surgery	☐ Ear infections	☐ Low blood pressure	☐ Psoriasis	☐ Tuberculosis
☐ Bowel disease	☐ Eczema	☐ Lupus	☐ Raynauds	☐ Ulcer
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rehumatic fever	☐ Venereal disease
☐ Carpal tunnel	☐ Fatigue	☐ Migraine headaches	☐ Scarlet fever	☐ Drug/Alcohol Dependence
☐ Chicken pox				

_____ Other Condition Not Listed ____

_____ Allergies (Please check any of the following items that you have allergic reactions to)

☐ Soap ☐ Lotions ☐ Vinyl ☐ Oils ☐ Detergent ☐ Fragrances ☐ Latex ☐ Other ______________________

1. Have you had any surgeries or been hospitalized? ☐ Y ☐ N, if yes, please explain:____
2. Please list ALL medications/vitamins/supplements you are currently taking or those, which you have discontinued, but took for a long period of time: ____

Please only fill out the following sections that apply to you

NECK REGION

1. Mark any of the following activities that increase you neck pain: ____ reading ____ standing ____ turning head ____ stress ____ other ______________________________
2. Do you get dizzy when you look up or twist you head? ____ Y ____ N
3. If your neck pain is a result of an old injury, did you hear any popping/snapping/tearing? Circle the correct answer.
4. Have you been diagnosed as having disc degeneration or bulging/herniation in your neck in the past? ____ Y ____ N
5. Do you have headaches that you think may be related to your neck pain? ____ Y ____ N
6. Does coughing, sneezing, or bowel movements increase your pain? ____ Y ____ N

ARM, HAND, AND FINGER REGION:

1. Do you have pain, numbness, swelling, or tingling in you shoulder / upper arm / forearm hand? Please circle which and indicate which side. Left, Right or Both
2. Do you feel weakness in your grip strength or have you noticed you are dropping objects recently? ____ Y ____ N
3. Do your arm symptoms change when you lift your arms over your head? ____ Improve _____ Worsen _____ Stay the Same

MID BACK AND CHEST WALL REGION

1. Does your mid back pain intensify when you take a deep breath? ____ Y ____ N
2. Does your mid back pain intensify when you twist your torso? ____ Y ____ N
3. Do you have a tight feeling in your chest or down your left arm? ____ Y ____ N
4. Do you have shortness of breath? ____ Y ____ N

LOW BACK, HIP AND LEG/FOOT REGION:

Check all the following movements that intensify low back pain or leg symptoms and write where you feel the pain with these actions?

☐ Sitting ☐ Standing ☐ Bending Forward ☐ Bending Backward ☐ Standing Up ☐ Lying on Your Back ☐ Walking

Check any locations of any current leg pain, numbness or tingling:

☐Hip ☐ Groin Area ☐ Buttock ☐ Back of Thigh ☐ Front of Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot/Toes

1. If your back pain is a result of an injury, did you hear any popping/snapping/tearing? Circle the correct answer.
2. When you cough, sneeze, or bear down to have a bowel movement, does you low back/leg pain get worse? ____ Y____ N
3. Is your low back pain relieved by any type of postural change? ____ Y ____ N If yes, circle all that apply: sitting straight, bending forward, bending backward, bending left, or bending right.
4. Have you ever been diagnosed as having a herniated/bulging disc or stenosis in your low back? ____ Y ____ N
5. Have your anal-rectal region been completely numb recently or have you had any significant changes in your bowel/bladder habits? ____ Y ____ N
6. Have you had any difficulty with walking? ____ Y ____ N

***I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information could be detrimental to my health.**

_________________________ ____

DATE **PATIENTS'S SIGNATURE**

Name:___________________________________ **Application For Care**

1. Please describe the health problem, for which you are seeking care: ____

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3. Have you ever had these symptoms before this episode? ☐ Y ☐ N, if yes, how many times in the past have you felt them.
(That lasted at least one day, but went away completely) ☐ 1-5 times ☐ 6-10 times ☐ >10 times

4. Have your symptoms: ☐ Improved ☐ Worsen gradually ☐ Worsen quickly ☐ Stayed the same

5. Mark areas on the diagram at the right where you feel discomfort/symptoms:

6. When was the first time you felt these symptoms? _____________________

7. Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Night ☐ sleeping

8. Are your symptoms: ☐ <25% of the time ☐ 25%-50% ☐ 50% -90% ☐ 100%

9. Describe pain/sensations in the affected body parts and when it started (burning, tingling, numbness, pins & needles, sharp achy dull achy dull, etc.)
Head________ Neck ________ Shoulder ________ Back ________ Groin ____________ Arms ________________
Hands ___________ Leg(s) ___________ Foot/Feet ___________ Other _____________________________

10. Please mark the scale to show how bad your discomfort has been recently. Please mark more than one area, and rate each pain, if you have more than one symptom.
No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst possible discomfort

11. Describe what makes your symptoms worse: ____

12. Describe what makes your symptoms better: ____

13. Have you had treatment for this condition before? ☐ Y ☐ N, if yes, please state when you were treated, the name of the practitioner, and the results attained. ____

14. Do you have any recent x-rays (within the last 12 months) ☐ Y ☐ N

15. Do you exercise regularly? Please describe ____

16. Do you smoke? ☐ Y ☐ N, if yes, how much _______ drink alcohol? ☐ Y ☐ N, If yes, how much and how often? ________________

17. Do you sleep poorly at night? ☐ Y ☐ N 2. Do you sleep on your stomach? ☐ Y ☐ N

18. Is your pain constant and significantly worse at night? ☐ Y ☐ N

Patient Goals: Please write down what you hope to achieve by becoming one of our patients. We have listed a few common ones

☐ Get out of pain ☐ Work out with no pain ☐ Increase my range of motion ☐ Perform better in sports

Please list any other goals that are not listed above ____

Women Only

Are you or could you be pregnant? ☐ Y ☐ N 2. Are you still having menstrual periods? ☐ Y ☐ N, if yes, when was the first day of you last menstrual period? _________

Family Health History

1. Do you have any relatives with similar problems? ☐ Y ☐ N If yes explain: ____________________________________
2. Is there family history of: ☐ Cancer ☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Other If yes, please explain:
____

Past History

Please write in the year/years in which you had any of the following **and** mark **X** if you currently have any:

- Anemia
- Angina
- Appendicitis
- Arteriosclerosis
- Arthritis
- Asthma
- Back/Neck surgery
- Bowel disease
- Cancer
- Carpal tunnel
- Chicken pox
- Diabetes
- Digestive disorder
- Dizziness/Fainting
- Double vision
- Sexual abuse
- Depression
- Ear infections
- Eczema
- Epilepsy
- Fatigue
- Heart attack/Disease
- Heartburn
- Hepatitis
- High blood pressure
- HIV infection/positive
- Kidney stones/disease
- Low blood pressure
- Lupus
- Measles
- Migraine headaches
- Mumps
- Pleurisy
- Pneumonia
- Polio
- Poor circulation
- Prostate hypertrophy
- Psoriasis
- Raynauds
- Rehumatic fever
- Scarlet fever
- Gout
- Mutlipe sclerosis
- Sinus problems
- Stoke
- Thyroid problem
- TMJ
- Tuberculosis
- Ulcer
- Venereal disease
- Drug/Alcohol Dependence

_____ Other Condition Not Listed ____

_____ Allergies (Please check any of the following items that you have allergic reactions to)

☐ Soap ☐ Lotions ☐ Vinyl ☐ Oils ☐ Detergent ☐ Fragrances ☐ Latex ☐ Other ______________________

1. Have you had any surgeries or been hospitalized? ☐ Y ☐ N, if yes, please explain:____

2. Please list ALL medications/vitamins/supplements you are currently taking or those, which you have discontinued, but took for a long period of time: ____________________________________

Please only fill out the following sections that apply to you

NECK REGION

1. Mark any of the following activities that increase you neck pain: ____ reading ____ standing ____ turning head ____ stress ____ other ____________________________
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Check any locations of any current leg pain, numbness or tingling:

☐Hip ☐ Groin Area ☐ Buttock ☐ Back of Thigh ☐ Front of Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot/Toes

1. If your back pain is a result of an injury, did you hear any popping/snapping/tearing? Circle the correct answer.
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4. Have you ever been diagnosed as having a herniated/bulging disc or stenosis in your low back? ____ Y ____ N
5. Have your anal-rectal region been completely numb recently or have you had any significant changes in your bowel/bladder habits? ____ Y ____ N
6. Have you had any difficulty with walking? ____ Y ____ N

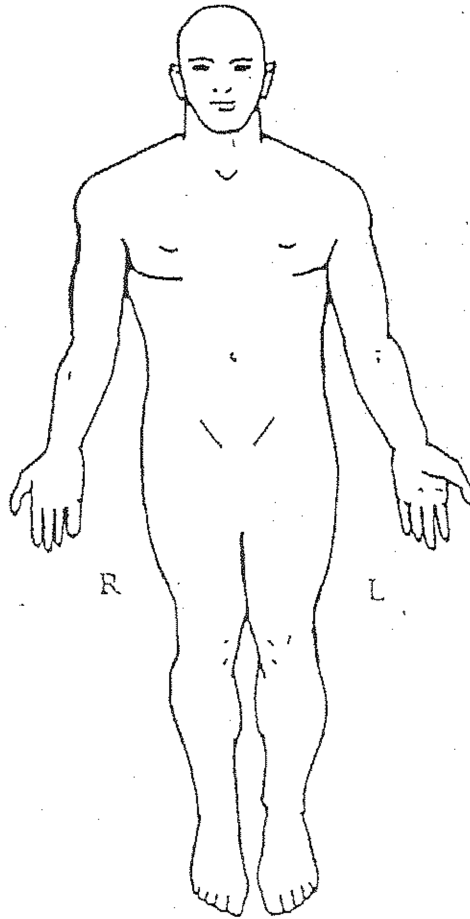
***I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information could be detrimental to my health.**

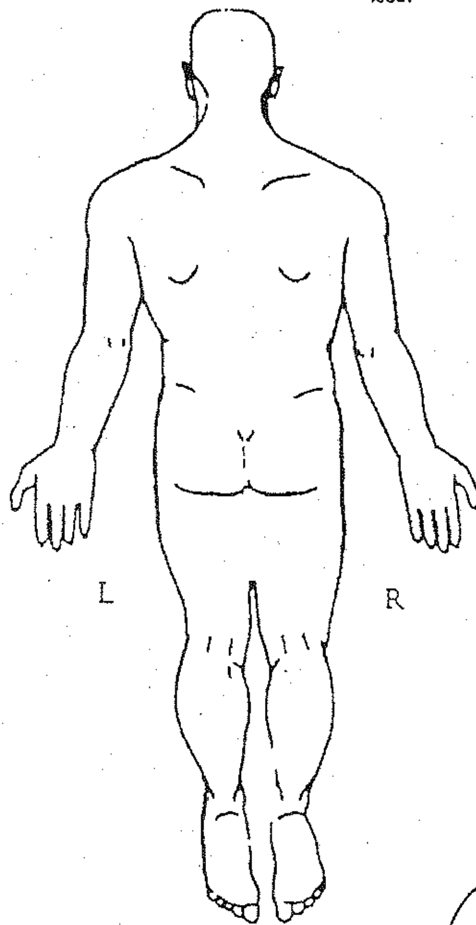
________________________ ____

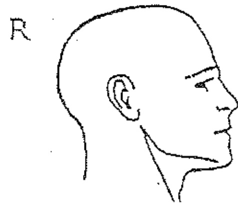
DATE **PATIENTS'S SIGNATURE**

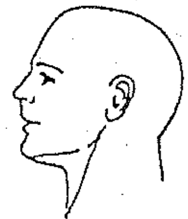
Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.

Numbness	Pins & Needles	Aching	Cramping	Burning	Stabbing
▪▪▪	oooo oooo oooo	✓✓✓✓ ✓✓✓✓ ✓✓✓✓	•••• •••• ••••	xxxx xxxx xxxx	//// //// ////









Name:

Date: