Today's Date___________

Full Name ____ DOB________________ Age_________ Sex: ____M ____F

Social Security Number _______________________ Email ____

Home Address ______________________________________ City _________________________ State______ Zip ___________

Home Phone _________________________ Work Phone __________________________ Cell Phone: _______________________

Employer___________________________________ Job Title _____________________________ How long at this job ___________

College/High School Students: Name of School____Grade: ___________

College Students: Student Local Address _____________________________________Student Phone Number _________________

Insurance primary card holder: Self Mother Father Husband Wife Other (circle one)

Name and **address** of insurance card holder (Primary card holder's name & address):

____

REASON FOR BEING SEEN TODAY:

1) Were you referred to Sport & Spine Physical Therapy by a physician? Yes No

If yes, name of referring physician:___________________________________ Clinic: ______________________________

Date Seen: ___________________________ Treatment: ____

Did Treatment Help? Yes No

2) Please check the body part(s) that you are being seen for today? (check all that apply)

____ Head	____ Chest	____ Elbow	____ Hip	____ Ankle
____ Neck	____ Stomach	____ Forearm	____ Thigh	____ Foot
____ Mid-back	____ Shoulder	____ Wrist	____ Knee	
____ Low back	____ Upper Arm	____ Hand	____ Calf	

Other: ____

3) Date of injury________________

Don't know but has been a problem for

_____ 1-2 weeks ____ 2-4 weeks _____1-2 months ______2-6 months _____ 6-12 months _____ Over one year

How did you injure yourself?

_____ Don't know _____ Chronic pain ____ Work Comp Injury _____ Motor Vehicle Accident

_____ Sports injury _____ Accident Other____

Over time has your condition: _____ Improved _____Worsened _____ Not Changed

(Continued on back)

Have you previously been to Sport & Spine? No Yes If yes, who did you see? ______________________________

GENERAL HEALTH HISTORY

Have you ever had an allergy or sensitivity to medicines or other substances? Yes No

Please List ____

Please list what you are currently taking

a. Medications (prescription and non-prescription ____________________________

____

b. Vitamins/Herbals____

____

Past adult or childhood injuries/illnesses that may pertain to current problem or effect our treatment____________________

Major medical problems ____

All prior surgeries ____

I authorize employees of Sport & Spine Physical Therapy to discuss my case, as necessary, with the following persons:

Spouse ____________________ Father: ____________________
Name Name

Mother ____________________ Other: ____________________
Name Name

None ☐ (Check if you do not want your case discussed with anyone)

Signature: ______________________________ Date: ____________________

SPORT & SPINE PHYSICAL THERAPY
AUTHORIZATION TO RELEASE INFORMATION

Authorization to Release Medical Information to Insurers
I authorize Sport & Spine PT, its employees or agents, to release all medical information necessary for processing insurance claims to all insurers, their agents or review organizations; and/or the Centers for Medicare and Medicaid Services (CMS) or its agents.

Authorization to Release Insurance Information to Sport & Spine PT
I authorize Sport & Spine PT, its employees or agents, to contact my insurance company or health plan administrator, their agents, or review agencies, or other third party payer to obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company or health plan administrator, their agents or review agencies, or other third party payer to release such information to Sport & Spine PT.

Authorization to Assign Benefits
I authorize and request my insurer to pay directly to Sport & Spine PT any benefits due under the terms of this policy for services provided by Sport & Spine PT. I understand that Sport & Spine PT reserves the right to refuse such assignments of medical benefits. If my health insurance will not allow direct payment to Sport & Spine PT or if Sport & Spine PT chooses not to accept assignment of medical benefits, I agree to immediately forward to Sport & Spine PT all health insurance payments I receive.

Authorization to Release Medical Information to Billing Addressee
I authorize Sport & Spine PT, its employees or agents, to release medical information as part of handling the billing, payment and insurance coverage for my account to the person(s) I have designated as my Billing Addressee.

Authorization to Release Medical Information to Other Health Care Providers
I further authorize Sport & Spine PT, its employees or agents to release medical information to my other health care providers for continuing care purposes.

These authorizations are valid until revoked by me at any time by notifying Sport & Spine PT in writing, except to the extent that Sport & Spine PT has already taken action in reliance upon it. This form supersedes all prior versions of this form signed by me.

Statement of Financial Responsibility
I acknowledge I am responsible for all charges for services provided to me including any amount not paid by my insurance plan(s).

Statement of Receipt of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
I acknowledge that I received a copy of the HIPAA Notice of Privacy Practices.

Statement of Referral of Primary Care Physician/Clinic
I acknowledge that I am responsible for obtaining a referral from my primary care physician/clinic if my insurance company so requires.

If your insurance company <u>does</u> require a referral, this is notification that you have <u>two working days</u> to obtain a referral. You are responsible for the full bill if no referral is received by this facility.

<u>ATTENTION:</u>

- If the patient is 18-years of age or older, the patient must sign and date the form.
- If the patient is 18-years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority:

  ☐ Legal Guardian ☐ Conservator ☐ Health Care Power of Attorney ☐ Relative

- If the patient is 17-years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

  ☐ Parent ☐ Legal Guardian ☐ Other: ________________________

Signature Required: ____ **Date**: ___________________

Print Name if Other Than Patient: ____

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

3. Copay amounts for services rendered are due at each visit unless special arrangements are made with the Income Manager. We also send out a monthly billing statement that will reflect payment received by your insurance company. Electronic billing is done daily with the insurance carriers. We accept cash, checks, MasterCard and Visa.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.

5. All credits on patient accounts will be refunded once we have received insurance data on all dates of service we have billed them for, and the patient has concluded their therapy.

6. If this injury is work related and a Workers Compensation claim has been initiated, **we must have a claim number and address to remit the claim within 7 days of your initial visit.** If a claim number has not been received or your case is denied by Workers Compensation, then you are responsible for each visit. We require, on your initial visit, that you provide us with your personal medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with this information on the registration form.
   ****Cancelled appointments or Failure to attend appointments, as defined by Physician or Physical Therapist, will be recorded and your Work Comp adjuster will be notified. Patient Initials ______________.**

7. For liability cases where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. <u>It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.</u>

8. We utilize electronic billing to submit your claim to your insurance carrier. Electronic billing requires the use of your social security number and full insurance information. If you choose not to provide your social security number, you will be responsible for filing your own insurance claim. If you do not provide your insurance card for us to verify and process your insurance, you will be responsible for payment of your account and for filing your own insurance claim.

9. When an appointment is cancelled or is a "no-show", it not only can affect your therapy but also takes away an opportunity for another patient to attend therapy, as a result we reserve the right to charge a $25.00 fee for cancellations or "no-shows".

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

I have read the above policies and agree.

SIGNATURE ____________________________________ DATE _________________

________ Receptionist Initials