SPORT & FAMILY PHYSICAL THERAPY

Name:_____ Male/Female

Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Work#:_____ Cell#:_____

Date of birth:_____

May we have your email address to inform you of clinic events and specials? Yes

_____ No

Area of injury:_____ Date of onset:_____

Referring Doctor:_____ Phone#:_____

Primary Care Physician:_____ Phone#:_____

Primary Insurance:_____ Phone#:_____

Policy holder:_____ Relationship to patient:_____

Policy holder's DOB: (if different from patient) _____

Policy #:_____ Group#:_____

Secondary Insurance:_____ Phone#:_____

Policy holder:_____ Relationship to patient:_____

Policy#:_____Group#:_____

If injury related to work/auto accident please circle and fill out below: WORK / AUTO

Insurance carrier name:_____ Claim#:_____

Phone#:_____Adjuster:_____

Attorney:_____ Phone#:_____

Date of Evaluation:_____ Time:_____ Office: WAVERLY

Please look over to make sure all information is accurate. Thank you.

SPORT & FAMILY PHYSICAL THERAPY

CONSENT TO TREAT/ASSIGNMENT OF BENEFITS/MEDICAL RELEASE/ MISSED APPOINTMENT POLICY

I hereby consent to evaluation and treatment by my physical therapist at Sport & Family Physical Therapy (SFPT). I am responsible for notifying SFPT of any changes in insurance information or in any medical health changes. I understand that I will make every effort to collect payment from my insurance company:
However, I understand that regardless of my account status, I am ultimately responsible for all charges incurred for services rendered at SFPT to the extent the law allows.

I hereby give permission to Sport & Family Physical Therapy to release medical information to my insurance company, physician, attorney, assignees, and/or beneficiaries.

I authorize payment of my insurance benefits directly to Sport & Family Physical Therapy for all services I receive.

- I am responsible for the co-payment/coinsurance/deductible portion that my insurance plan does not cover.
- I am responsible for supplying SFPT with prescriptions/referrals that are required according to my insurance plan.
- If injury related to an automobile accident we will bill your auto insurance first and thereafter, if your PIP is exhausted, we will bill your personal health insurance for the remainder balance due. If there is no personal health insurance, I will be responsible for payment.
- If work related injury we will bill your workman's comp. insurance as long as there is an open, acceptable claim with claim number and preauthorization of treatment.

Missed appointment policy: We require 24 hours notice for all appointments that need to be cancelled or rescheduled. Failure to provide notice timely may result in a $25 fee that your insurance will not cover.
We appreciate your cooperation and understanding with this policy. It is to best serve our patients.

I have read and understand the terms above and agree to terms listed.

Signature:_____
Date:_____

SPORT & FAMILY PHYSICAL THERAPY

HIPAA REGULATIONS
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
(we will be sending your reports to the physician you supply to us)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source of information for applying my diagnosis and physical therapy information to my bill
4. A means by which a third-party payer can verify that services billed were actually provided
5. And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Sport & Family Physical Therapy reserves the right to change their notice and practices at any time. In this event, prior to implementation, they will mail a copy of any revisions to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signature of Patient: _____ Date:_____

or

Signature of Legal Representative_____ Date:_____

Sport & Family Physical Therapy

Patient History Intake

NAME: _____ **DATE**: _____

AGE: _____ **SEX**: M F Height:_____ Weight: _____ Dominant Hand: R L

WORK INFORMATION: Occupation:_____ Presently working Y N
If working Hours/Week:_____ Duty: Regular Light Restricted by present problem Y N

HISTORY: Involved side: R L Both **Date of onset of Problem:** _____

How did your problem occur:

_____
_____

MEDICAL INFORMATION:

Physician:_____ Diagnosis:_____
Medical Tests: X-Ray____ CAT scan_____ Bone Scan____ MRI ____ EMG _____
Nerve conduction_____ Arthrogram_____ other_____ Result: _____
Surgery:_____
Did you use Cast ___ Splint ____ Date applied:_____ Date removed: _____

MEDICATIONS: _____

OTHER MEDICAL PROBLEMS: (Diabetes, High Blood Pressure, Heart disease, cancer, use of pace maker)

_____
_____

PAIN: (0= no pain 3 = headache type pain 5 = makes you stop what you are doing
7= makes you lie down 10= worst pain ever
Use the above 0-10 pain scale to describe your pain associated with this problem

_____