



PATIENT MEDICAL HISTORY

Name: _____ **Referring Physician:** _____
Family Physician: _____ **Date of first doctor visit for this injury:** _____
Last date worked due to this injury: _____ **Occupation** _____
Date returned to work after this injury: _____ **Is Attorney involved in this Case: YES NO**
Have you had surgery for this injury? YES NO **Number of surgeries: 1 2 3 4**
Type of surgery: _____ **Took Place in: Hospital Surgery Center**

Are you currently taking any prescription or non-prescription medications? YES NO

| | |
|---------------------------|------------------------|
| Anti-Inflammatories _____ | List Medications _____ |
| Muscle Relaxer _____ | _____ |
| Pain Medication _____ | _____ |

Have you had any of the following medical or rehabilitative services for this injury/episode?

| | YES | NO | | YES | NO |
|----------------------|-------|-------|----------------------|-------|-------|
| Chiropractor | _____ | _____ | CT Scan | _____ | _____ |
| EMG/NCV | _____ | _____ | General Practitioner | _____ | _____ |
| Massage Therapy | _____ | _____ | MRI | _____ | _____ |
| Myelogram | _____ | _____ | Neurologist | _____ | _____ |
| Occupational Therapy | _____ | _____ | Orthopedist | _____ | _____ |
| Physical Therapy | _____ | _____ | Podiatrist | _____ | _____ |
| Emergency Room Care | _____ | _____ | X-Rays | _____ | _____ |
| Other: _____ | | | | | |

Do you now have or have you ever had ANY of the following?

| | YES | NO | | YES | NO |
|----------------------------------|-------|-------|--------------------------------|-------|-------|
| Asthma, Bronchitis | _____ | _____ | Severe or Frequent Headaches | _____ | _____ |
| Shortness of Breath/Chest Pain | _____ | _____ | Vision or Hearing Difficulties | _____ | _____ |
| Coronary Heart Disease or Angina | _____ | _____ | Numbness or Tingling | _____ | _____ |
| Do you have a Pacemaker? | _____ | _____ | Dizziness or Fainting | _____ | _____ |
| High Blood Pressure | _____ | _____ | Ringing in your Ears | _____ | _____ |
| Heart Attack or Surgery | _____ | _____ | Weakness | _____ | _____ |
| Stroke/TIA | _____ | _____ | Weight Loss/Energy Loss | _____ | _____ |
| Blood Clot/Emboli | _____ | _____ | Hernia | _____ | _____ |
| Epilepsy/Seizures | _____ | _____ | Tuberculosis | _____ | _____ |
| Thyroid Trouble/Goiter | _____ | _____ | Allergies | _____ | _____ |
| Anemia | _____ | _____ | Any Pins or Metal Implants | _____ | _____ |
| Infectious Diseases | _____ | _____ | Joint Replacement | _____ | _____ |
| Diabetes | _____ | _____ | Neck Injury/Surgery | _____ | _____ |
| Cancer or Chemotherapy/Radiation | _____ | _____ | Shoulder Injury/Surgery | _____ | _____ |
| Arthritis/Swollen Joints | _____ | _____ | Elbow/Hand Injury/Surgery | _____ | _____ |
| Osteoporosis | _____ | _____ | Back Injury/Surgery | _____ | _____ |
| Gout | _____ | _____ | Knee Injury/Surgery | _____ | _____ |
| Sleeping Problems/Difficulties | _____ | _____ | Leg/Ankle/Foot Injury/Surgery | _____ | _____ |
| Emotional/Psychological Problems | _____ | _____ | Are You Pregnant? | _____ | _____ |
| Bowel or Bladder Problems | _____ | _____ | Do You Smoke? | _____ | _____ |

List any other information that would assist us in your care: _____

Are you aware of what your diagnosis is YES NO
Based upon your awareness, what are your expectations/goals while in this program?

Patient/Guardian Signature: _____ **Date:** _____
Therapist Signature: _____ **Date:** _____

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **SPORTSCARE PHYSICAL THERAPY, INC.** to furnish medical care and treatment to (patient) _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **SPORTSCARE PHYSICAL THERAPY, INC.** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customer fee schedule*, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **SPORTSCARE PHYSICAL THERAPY, INC.**

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

SPORTSCARE PHYSICAL THERAPY, INC. verifies benefits as a courtesy to you. However, SPORTSCARE PHYSICAL THERAPY, INC. does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

When you pay by check, you expressly authorize **SPORTSCARE PHYSICAL THERAPY, INC.**, if your check is **dishonored or returned for any reason**, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated **Clearing House Association**, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that **SPORTSCARE PHYSICAL THERAPY, INC.** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date



CANCELLATION AND NO-SHOW POLICY

Welcome to SportsCare Physical Therapy. In order to accommodate the scheduling needs of other patients as well as to allow us to properly schedule staffing needs, we require a 24 hour notice to cancel or reschedule an appointment.

Upon cancellation without 24 hour notice, a \$25 fee will be charged to you (not your insurance company) and will be collected prior to the subsequent visit. Please note that if multiple appointments are cancelled without notice, you may be discharged at the discretion of our staff.

In addition, due to high demand for Saturday appointments, any missed appointments/cancellations without notice by Friday morning may disqualify you from our weekend services.

Thank you for showing respect to our regular patients, to those who need emergent visits, and to our staff by cooperating with this policy.

I understand that SportsCare Physical Therapy requires a 24 hour notice for cancellation of scheduled appointments. I understand that I am financially responsible for late cancellations and missed appointments and a \$25 fee will be applied.

Patient/Guardian Signature

Date



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES***

**You may refuse to sign this acknowledgement*

SportsCare Physical Therapy, Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations.

Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information.

The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.

I, _____, have received/reviewed a copy of this facility's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's Medical Record