SPORTSCARE Physical Therapy

Orthopedic Rehabilitation Specialists

All information collected is confidential.

4310 Johns Creek Parkway, Suite 130
Suwanee, GA 30024
770-495-0610

3655 Howell Ferry Road, Suite 300
Duluth, GA 30096
678-878-2192

Name: _____ Name you prefer to be called: _____

Address: _____ Date of Birth: _____/_____/_____

City: _____State:_____ Zip: _____ Social Security Number: _____ - _____- _____

Sex: M / F Marital Status: _____ Occupation: _____

Primary Insurance: _____ Secondary Insurance: _____

Employer (Name & Address) _____
Is Patient a Student: Y / N If yes: Name of School: _____

CONTACT INFORMATION:

How do you wish to receive reminders about appointments?
(You may select more than one):
Phone / Email / Text

Email Address: _____

PHONE: _____ _____ _____
Home Work Cell
Where do you prefer to receive calls: Home / Work / Cell

Emergency Contact: Name: _____ Phone Number: _____

POLICY HOLDER INFORMATION: (if other than self):

Name of Policy Holder: _____ Relationship: _____

Policy Holder Date of Birth: _____ Social Security # _____-_____-_____

Address & Phone (if different from above): _____
( ) _____-_____
Policy Holder Employer: _____City: _____

Is this injury work related? YES NO
Is this injury due to an auto accident? YES NO STATE _____

SPORTSCARE Physical Therapy
Orthopedic Rehabilitation Specialists

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: _____ **Is this injury work related? YES_____ NO_____**
Is this injury due to an auto accident? YES_____ NO_____ **STATE_____**

1. Are you currently taking any prescription or non-prescription medications? YES___ NO___

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

2. Have you had any of the following medical or rehabilitative services for this injury?

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

Other: _____

3. How would you rate your overall health status? Excellent Good Fair Poor

4. Please rate your pain level from 0-10 under the following circumstances:

At rest _____/10 At worst during the current episode of pain _____/10

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

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

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

7. Are you aware of what your diagnosis is? YES_____ NO_____
8. Based upon your awareness, what are your expectations/goals while in this program? _____
9. How did you hear about Sports Care Physical Therapy? _____

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

SPORTSCARE Physical Therapy
Orthopedic Rehabilitation Specialists

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 –printed name) _____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 benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers 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.**

I understand and agree that if my account is sent to our Collection Agency for payment that I will be assessed an additional charge that would increase my total bill by 34%. I further understand that I will also be responsible for any necessary attorney fees and legal costs.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

_____ _____
Patient/Guardian/Responsible Party Date

SPORTSCARE Physical Therapy
Orthopedic Rehabilitation Specialists

The Missed Visit Policy

At **SPORTSCARE PHYSICAL THERAPY,** our goal is to help all patients fully recover from injury and illness. At the end of your initial appointment, your physical therapist will provide you with a plan for your care based on their expertise and your goals.

Patients who attend all their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lowered potential for recovery. We do what we do to make sure YOU, and all our patients, have the best chance at recovery; but we need your participation in the plan of care to make that happen. To prevent others from having to wait for their care, we also need your compliance with our attendance policy.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To make sure you have the best chance at recovery, you'll need to schedule and arrive for your prescribed visits.
2. **We will begin your treatment sessions on time**, so we need you to arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at your scheduled appointment time.
3. **If you're running late**, we need you to call as soon as you know you're running late. We will check with your provider to make sure there's enough time to provide the care you need and deserve.
    - If you are more than 15 minutes late, your session may need to be rescheduled and our missed visit policy will apply at that time. Chronically late patients will be asked to change their appointment times.
4. **If you are sick at any time during care, we need you to call us as soon as you have symptoms**. Please don't wait for the day of your appointment. At that time we will provide a plan for what happens next.
    - Example: If you're sick on Monday but your appt. is Wednesday, let us know Monday.
5. **If you need to cancel or change a scheduled appointment, for any reason, we need a 24 hour notice during business hours.**
    - This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
    - When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
6. **If you don't provide 24 hours for an appt. change or cancelation, you will be charged a $35.00**
    - This fee is your responsibility and is due at the time of your next service due to the inconvenience and disruption it creates for other patients seeking care.
    - We will comply with payer policy in carrying out this policy.
    - For worker's comp patients, we're required to notify your claims adjuster for cancellations and no-shows.
    - No-show appointments create problems and confusion and are not accepted. Call for any change or update.
7. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and placed on our day-to-day list to avoid future last-minute cancellations that keep other patients from care.

As I'm sure you understand, one patient's late (or lack of) notice for appointment changes or cancellations, keeps other patients from getting the care they need and deserve. You can avoid any problems with this policy by calling our office during business hours - at least **24 hours** in advance for any illness, appointment changes or cancellations.

Jeff Lewandowski DPT, SCS, MTC, ATC

This policy has been verbally reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

SportsCare Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SportsCare Physical Therapy***'s LEGAL DUTY***

SportsCare Physical Therapy is required by law to protect the privacy of your protected health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

SportsCare Physical Therapy uses your protected health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***SportsCare Physical Therapy*** may use your protected health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

SportsCare Physical Therapy may also use or disclose your protected health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

Periodically, ***SportsCare Physical Therapy*** will use protected health information contained in its records without obtaining patients' prior authorization to develop marketing materials. Protected health information used in this way will be "de-identified" by removing all information that could distinguish the individual's record from a group of records.

SportsCare Physical Therapy does not participate in the selling of patients' health information. If your information is sold, prior notification and written authorization is required.

In any other situation, ***SportsCare Physical Therapy***'s policy is to obtain your written authorization before disclosing your protected health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

SportsCare Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your protected health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your protected health information for reasons other than treatment, payment or other related administrative purposes. You may be charged a fee for the paper, labor, postage, preparation of an explanation.

You may also request in writing that we not use or disclose your protected health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***SportsCare Physical Therapy*** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

If you pay out-of-pocket for everything for a particular treatment (not just their co-pay or deductible for example) and do not ask to bill your health plan for that treatment, then you can request that ***SportsCare Physical Therapy*** not disclose information about that treatment to the health plan.

In the event of an information breach, all affected individuals will be notified within a reasonable period not to exceed 60 calendar days.

CONCERNS AND COMPLAINTS

If you are concerned that ***SportsCare Physical Therapy*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your protected health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***SportsCare Physical Therapy***'s health information practices or if you have a complaint, please contact the following person:

SPORTSCARE PHYSICAL THERAPY

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand ***SportsCare Physical Therapy's*** Notice of Information Practices. I understand that ***SportsCare Physical Therapy*** may use or disclose my protected health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my protected health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***SportsCare Physical Therapy's*** PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my protected health information for purposes as noted in ***SportsCare Physical Therapy***'s Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

I also authorize ***SportsCare Physical Therapy*** to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____

Patient Name

_____

Signature

_____

Date

SPORTSCARE Physical Therapy

Orthopedic Rehabilitation Specialists

Patient Name: ____

Medication List for Medicare Patients

(Including ALL vitamins and supplements)

Name of Drug/ vitamin/supplement	Dosage	Frequency	Route (Oral, injected, etc.)