PATIENT INFORMATION FORM
SPINE & SPORT PHYSICAL THERAPY

Patient Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

(if different than home)

Telephone: _____ Driver's License#: _____

Cell phone: _____ E-mail_____

Date of Birth: _____ Soc. Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Injury: _____ Referring Physician: _____

Employer: _____ Phone#: _____

Address: _____City : _____ State: _____ Zip: _____

Was injury employment related? Yes ☐ No ☐

Auto Accident? Yes ☐ No ☐

Payor (party responsible for payment): _____

Address: _____ City: _____ State: _____ Zip: _____

Do you have an attorney for this injury? Yes ☐ No ☐

Attorney's Name: _____

Address: _____Phone#: _____

Signature: _____ D**ate:** _____

PATIENT HISTORY FORM
SPINE & SPORT PHYSICAL THERAPY

Patient Name: _____ Gender: _____ Date of Birth: _____

Have you ever experienced or been diagnosed with any of the following:

	Yes	No		Yes	No
High Blood Pressure			Headaches		
Heart Trouble			Rheumatic Disease		
Circulation Problems			Seizures		
Blood Clots			HIV/AIDS		
Stroke			Cancer		
Dizzy Spells			Hepatitis		
Breathing Problems			Mental Illness		
Fractures			Fibromyalgia		
Osteoporosis			Diabetes		
Arthritis			Sudden Weight Loss/Gain		
Hearing Change/Problems			Tuberculosis		
Vision Change/Problems			Other:		

Height: _____ Weight: _____

Have you ever had Surgery? Yes ☐ No ☐

If yes, give date(s) and operation(s)_____

_____

Do you have any metal in your body (other than your teeth)? Yes ☐ No ☐

Do you have a Cardiac (heart) Pacemaker? Yes ☐ No ☐

(For Women) Are you currently pregnant? Yes ☐ No ☐
Date of last period_____

List any Allergies you have_____

Have you ever had physical therapy treatments before? Yes ☐ No ☐

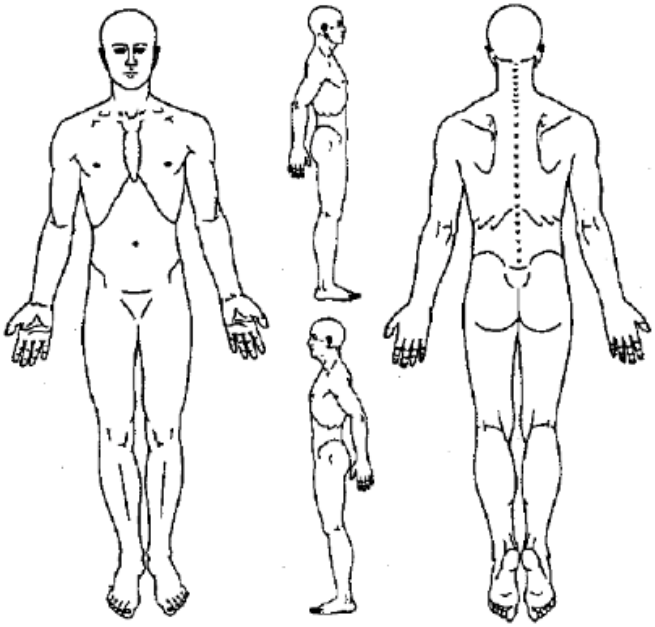
If yes, indicate Where, When and for What problem_____

_____

Describe briefly the history of your present accident/illness/injury_____

_____

Please use XXXX's to indicate on the diagram where you are currently experiencing pain and ////'s where you are experiencing numbness or tingling.



Do you smoke? Yes☐ No☐
Packs per day_____ Since_____
Do you drink? Yes☐ No☐
How many drinks per day_____ per week_____

Do you exercise? Yes☐ No☐
How many days per week _____ How long per session _____

What type of exercise_____

Work: Employed ☐Unemployed ☐ Retired ☐ Disabled☐Student

Current Occupation:_____

Hobbies: _____

Do you give permission to fax your medical records to your doctor? Yes☐ No ☐

_____ _____

Signature **Date**

If not Patient, indicate relationship (Parent, Guardian, Other): _____

MEDICATION LIST

Name:_____ **Date:**_____

List all current prescription, over the counter, herbals, vitamins/mineral/dietary supplements including name, dosage, frequency, and route of admission (how medication/supplement is taken).

Name of medication/supplement	*Dosage*	*Frequency*	*Route of admission (How the medication is taken)*

I,_____, have reviewed the above medication list with _____.

(therapist name) **(patient name)**

_____ _____

Therapist Signature **Date**

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

SPINE & SPORT PHYSICAL THERAPY

EFFECTIVE DATE DECEMBER 1, 2008

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Kevin Forrer, PT, DPT, Physical Therapist and Privacy Official at (540)868-9599.

WHO WILL FOLLOW THIS NOTICE:

- Spine & Sport Physical Therapy, PLLC

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Kevin Forrer, PT, DPT, Physical Therapist and Privacy Official at (540)868-9599.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Kevin Forrer, PT, DPT, Physical Therapist and Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

1. **Acknowledgement of Receipt of Notice of Privacy Practices**

I, _____, have received the Notice of Privacy Practices from Spine & Sport Physical Therapy.

Signature:_____ **Date** _____

In lieu of patient signature, I, _____, a staff member of Spine & Sport Physical Therapy state that _____ has been given our current Notice of Privacy Practices.

Signature:_____ ***Date*** _____

2. **Discussion of Treatment/Medical Information**
   a. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present?
      - Yes ☐ No ☐
   b. Is there any individual, besides your doctor and involved health care practitioners, with whom Spine & Sport Physical Therapy has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	☐	_____
Son/Daughter	☐	_____
Son-in-law/Daughter-in-law	☐	_____
Friend	☐	_____
Other	☐	_____

   c. Spine & Sport Physical Therapy is actively involved in the clinical education of physical therapy interns who have completed accredited programs at respected Universities.
      i. I grant permission for the intern to be involved in my care, in conjunction with the primary physical therapist, in ways which may involve review of relevant personal health information, discussion and observation.
         - Yes ☐ No ☐
      ii. I permit the intern to execute care procedures as directed/supervised by the primary physical therapist such as exercise instruction, massage, range of motion and stretching.
         - Yes ☐ No ☐
   d. Office staff of Spine & Sport Physical Therapy has permission from the patient to leave a message at the following locations if necessary:

      Please check if you grant permission:
      ☐ Home Answering Machine
      ☐ Cell Phone
      ☐ Work
      ☐ Family Member

3. **Place of Treatment**
   a. To facilitate your care, a portion of your treatment may take place in the open gym area of our clinic. Do you agree to this?
      - Yes ☐ No ☐

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**

- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

- The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain, if you don't understand why Medicare won't pay. Ask us how much these items or services will cost you (**Estimated Cost: $**_____).

Medicare will not pay for: Over $2,110 of Physical Therapy and Speech Therapy Services in 2021

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

_____ _____

Beneficiary Signature **Date**

FINANCIAL POLICY AND CONTRACT

Dear Patient,

We will bill your insurance for the physical therapy services. Our office staff is experienced and will help you get maximum benefit from your policy. You must read your policy and be familiar with its main features. Ask our Office Manager for help to understand its benefits. We will verify your insurance coverage by your second appointment and notify you if we need more information. 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.

Please read and sign the following Policy and Contract. Ask the Receptionist or Office Manager if you have any questions.

1. Your policy may pay less than our customary fee. Not all services are a covered benefit in all policies. You should discuss payment of the balance with the Office Manager.

2. The insurance company is your company. Your insurance policy is a contract between you, your employer and the insurance company. Do not hesitate to call them if you have a question regarding payment. This document is a contract between you and Spine & Sport Physical Therapy.

3. We should receive payment from the insurance company within 45 days. After 45 days, you are responsible for the balance.

4. You must make arrangements to pay the percentage not covered by your policy, if your policy pays less than 100%. You will receive a statement (at least monthly) indicating the balance due. Payment is due at the time services are rendered. We accept cash, checks, Mastercard or Visa.

5. If you have a co-pay, you should pay when you arrive for each appointment.

6. By signing this document, you are promising to pay any balance left after insurance proceeds are received by Spine & Sport Physical Therapy.

Cancellations: Please notify us as soon as possible if you must reschedule your appointment. 24-hour notice is appreciated. If a cancellation is made the same day as the appointment and the time cannot otherwise be filled, a $30.00 charge will apply.

No Shows: Missed appointments without notification are charged $30.00 due to the scheduling inconvenience. This is **NOT** paid by insurance.

Litigation & Third Party Payor: We do not see patients with the expectation of payment contingent on the outcome of any litigation. If you are anticipating payment for services by another party's insurer, we still expect payment when the service is rendered. We will bill your insurance on your behalf. You should pay any percentage not covered by your own policy.

(OVER)

Interest Charge: Services paid for within ninety (90) days of the service date are not subject to an interest charge. A 1.5% per month interest will be charged to all balances over ninety (90) days.

Attorney's Fees: You agree to pay, in addition to the balance due and the applicable finance charge, an amount equal to thirty-three and one-third percent (33-1/3%) [or the maximum permitted by law, whichever is less] of the balance due as attorney's fees if this account is referred to an attorney for collection.

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered.

I certify that all information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status of the above information.

PLEASE SIGN → _____ _____
Signature **Date**

I certify that I have read both sides of this document and agree to the terms and conditions herein.

PRINT FULL NAME _____

PARENT(S), IF PATIENT
IS A MINOR _____

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the Physical Therapy practice and agree that I am financially responsible for all non-covered services including interest, cancellation, and no-show charges. I also authorize the physical therapist to release any information required to process insurance claims.

Please feel free to discuss any facet of your medical insurance coverage with us.

AGREED:

PLEASE SIGN → _____ _____
Signature **Date**

_____ _____
Signature of Insured, if not the Patient **Date**

MEDICARE WAIVER

Name:_____
(Print Name)

Date:_____

Description of Service: Outpatient physical therapy Part B providers

NOTICE: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. We believe that, in your case. Medicare is likely to deny payment for the following service/items:

- Provision of exercise tools (e.g. bands, balance boards, biofeedback devices, theraputty), soft goods (e.g. braces, orthotics, molded insoles), or supplies (e.g. tape, electrodes and dressings), iontophoresis.

I have been notified by my Physical Therapist that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

(Beneficiary Signature) **(Date)**