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: ____ **Date:** _______________________

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

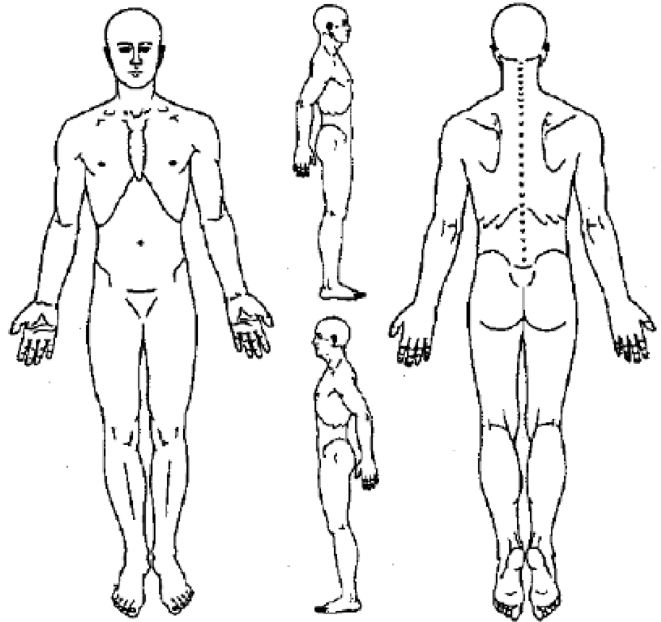
If yes, indicate Where, When and for What problem____

____

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.

X__________________________________ 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.

X__________________________________ 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	Y____	N_____	____________________________
Son/Daughter	Y____	N_____	____________________________
Son-in-law/Daughter-in-law	Y____	N_____	____________________________
Friend	Y____	N_____	____________________________
Other	Y____	N_____	____________________________

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 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______

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

Do you wish to have Appointment Reminders?

Yes ☐ No ☐

Text or Voicemail (Circle one)

Phone Number:_______________________

3. **Place of Treatment**

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 ______

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 $50.00 charge will apply.

No Shows: Missed appointments without notification are charged $50.00 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 18% 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**