



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 _____ 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



**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 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