



**PATIENT INFORMATION** Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: M | S | D | W

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Was this an Auto Accident? Y | N Work Accident? Y | N Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Whom may we contact in an Emergency: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? (Check all that apply)**

Newspaper: \_\_\_\_ Phone Book: \_\_\_\_ Radio: \_\_\_\_ Return Patient: \_\_\_\_ Attorney: \_\_\_\_ Billboard/Sign/Location: \_\_\_\_

Doctor: \_\_\_\_ Insurance Provider: \_\_\_\_ Television: \_\_\_\_ Website: \_\_\_\_ Other: \_\_\_\_

Family/Friend: \_\_\_\_\_

**INSURANCE POLICY HOLDER**

Insurance Policy Holder Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Insured Party's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured Party's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



Thank you for choosing Sport + Spine. We look forward to helping you meet your rehabilitation needs. To help us serve you more efficiently, please read, sign, and date in the designated areas.

**CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for Sport + Spine to furnish medical care and treatment to \_\_\_\_\_ as considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I, the undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to Sport + Spine. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**COMMUNICATION AUTHORIZATION**

Please list below any other person(s) authorized by you, (in addition to legal guardian, family or referring physicians) to discuss aspects related to health care provided by Sport + Spine. (i.e. lawyer, coaches, employer, etc.)

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_

**FINANCIAL POLICY STATEMENT**

I understand I am responsible for all medical expenses incurred through Sport + Spine including any fees for late payments and/or qualified missed appointments. We require 24 hours to cancel or reschedule an appointment. No-shows or failure of notice to cancel will result in a \$50.00 fee. Should health insurance benefits be applicable for these expenses I authorize Sport + Spine to release to health insurance companies such information needed to process my claim with the health insurance agency. Any other release of information from my record will necessitate written authorization from me. Following discharge, any outstanding charges must be paid within 60 days of final bill. If bill remains unpaid, the largest of 5% or \$50 penalty charge will be assessed and all charges will be transferred to collections. I UNDERSTAND MY FULL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Sport + Spine Witness/Rep \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of 1<sup>st</sup> MD visit for this injury: \_\_\_\_\_

Is an Attorney involved in this case: YES NO

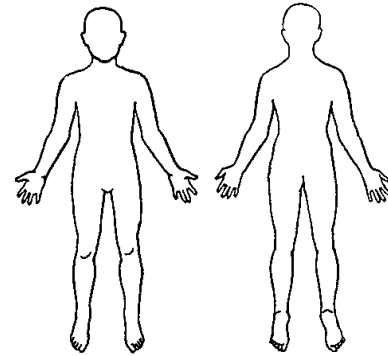
Have you had surgery for this injury: YES NO Type of Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Please list ALL prescription and non-prescription medication you are currently taking:

\_\_\_\_\_

Do you now have or have you ever had any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Asthma, Bronchitis, or Emphysema   | <input type="checkbox"/> Bowel and/or Bladder Dysfunction   |
| <input type="checkbox"/> Shortness of Breath                | <input type="checkbox"/> Severe or Frequent Headaches       |
| <input type="checkbox"/> Chest Pain / Angina                | <input type="checkbox"/> Vision or Hearing Difficulties     |
| <input type="checkbox"/> Coronary Heart Disease             | <input type="checkbox"/> Dizziness or Fainting              |
| <input type="checkbox"/> Pacemaker                          | <input type="checkbox"/> Numbness or Tingling               |
| <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Weakness                           |
| <input type="checkbox"/> Heart Attack or Heart Surgery      | <input type="checkbox"/> Unexplained Weight or Energy Loss  |
| <input type="checkbox"/> CVA (Stroke) / TIA (Mini Stroke)   | <input type="checkbox"/> Hernia                             |
| <input type="checkbox"/> Blood Clot / Emboli                | <input type="checkbox"/> Varicose Veins                     |
| <input type="checkbox"/> Epilepsy / Seizures                | <input type="checkbox"/> Allergies                          |
| <input type="checkbox"/> Thyroid Dysfunction / Goiter       | <input type="checkbox"/> Any Pins or Metal Implants         |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Joint replacement                  |
| <input type="checkbox"/> Infectious Diseases                | <input type="checkbox"/> Neck Injury / Surgery              |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Shoulder Injury / Surgery          |
| <input type="checkbox"/> Cancer / Chemotherapy / Radiation  | <input type="checkbox"/> Elbow / Hand Injury / Surgery      |
| <input type="checkbox"/> Arthritis / Swollen Joints         | <input type="checkbox"/> Back Injury / Surgery              |
| <input type="checkbox"/> Osteoporosis                       | <input type="checkbox"/> Knee Injury / Surgery              |
| <input type="checkbox"/> Gout                               | <input type="checkbox"/> Leg / Ankle / Foot Injury/ Surgery |
| <input type="checkbox"/> Sleep Disorders                    | <input type="checkbox"/> Are you Pregnant?                  |
| <input type="checkbox"/> Emotional / Psychological Problems | <input type="checkbox"/> Do you Smoke?                      |



**\*\* Please circle the location of your pain \*\***

Please provide us with any other information that would assist us in your care: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*\*You May Refuse to Sign This Acknowledgment\*\*

- A. I have received a copy of Sport + Spine’s Notice of Privacy Practices. YES NO Initial\_\_\_\_
B. I agree to the open treatment area used by Sport + Spine. YES NO Initial\_\_\_\_
C. I agree that a private treatment area is not necessary. YES NO Initial\_\_\_\_
D. I agree that, due to this open format, unauthorized individuals may have the opportunity to learn of my protected health information. YES NO Initial\_\_\_\_
E. I agree that PT/PTA students may participate in my physical therapy care. YES NO Initial\_\_\_\_
F. I authorize Sport + Spine and its employees to call me at my home with regards to my health status. YES NO Initial\_\_\_\_

Signature Please Print Name Date

For Office Use Only

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

- \_\_\_ Individual refused to sign
\_\_\_ Communications barriers prohibited obtaining the acknowledgement
\_\_\_ Emergency situation prevented us from obtaining acknowledgement.
\_\_\_ Other (please specify) \_\_\_\_\_

Signature Authorized Sport + Spine Representative Please Print Name Date