PATIENT INFORMATION

First Name: _____ Last Name: _____ MI_____

Male Female Date of Birth: ____/____/___ SS#_____

Marital Status: _____

Address 1:_____
Street Address City State Zip

Email: _____

Phone Numbers: Primary ( ) _____-_____Cell ( ) _____-_____Work ( ) _____-_____

Employer: _____Occupation:_____

Emergency Contact: _____Phone: ( ) _____-_____

Referring Physician: _____

INSURANCE INFORMATION

Primary Ins._____ Member #:_____Group #:_____

Subscriber Name: _____DOB:_____ Relationship to Patient: _____
(If different than patient)

Secondary Ins. _____Member#:_____Group#:_____

Subscriber Name: _____DOB:_____ Relationship to Patient: _____

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient name above at Sports Therapy and Rehabilitation.

Signature: _____Date_____
Parent or Legal Guardian must sign **if patient is under 18 years of age**

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an on-going process which requires regular attendance to be optimally effective. If I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. We **REQUIRE** a 24 hour advance notice of cancellation. If I fail to give notice for cancellation of an appointment, I will be charged $35 which is not covered by my insurance. **After TWO no-shows, I understand my appointments will be removed from the schedule.**

Please initial if read and understand_____

FINANCIAL POLICY AND INSURANCE INFORMATION

If we participate (are contracted) with an insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. You are responsible for payment of:

1. The annual deductible not yet met
2. Co-payment at time of visit
3. Co-insurance (% not covered by insurance)
4. Charges for non-covered services

I understand that if Sports Therapy and Rehabilitation is not contracted with an insurance plan in which I am under, they are not responsible to bill for payment for services rendered. We do not bill tertiary (third) insurance companies.

I hereby give authorization for payment of insurance benefits to be made directly to Sports Therapy. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered. I understand and agree that if it becomes necessary to commence legal actions for the collection of any outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance.

Returned Check Fee: A $35 fee will be charged to my account on any returned check.
Past Due Accounts: A 1.5% monthly finance charge will incur each month on any unpaid patient balance until the balance is paid in full. Delinquent accounts will be sent to an outside collection agency and charged a $50 administrative fee.

Signature of Person Responsible for Charges: _____Date:_____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

PREVIOUS PHYSICAL THERAPY/HOME HEALTH

During the current year, 2022, prior to receiving care from us, have you received physical therapy treatment elsewhere? **O** yes **O** no

During the current year, 2022, prior to receiving care from us, have you received or are you now receiving any Home Health Care? **O** yes **O** no If yes, were you discharged? **O** yes **O** no
Date of Discharge: _____Name of Agency: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Sports Therapy reserves the right to modify the privacy practices outline in the notice.

I have read and/or received a copy of the Notice of Privacy Practices for Sports Therapy & Rehabilitation.

Signature of Patient: _____**Date:**_____

MEDICAL HISTORY

PATIENT NAME: _____ **DATE:** _____

Date of Birth: _____ ☐ MALE ☐ FEMALE Height: _____ Weight: _____

Allergies	☐ YES	☐ NO	Depression	☐ YES	☐ NO	Multiple Sclerosis	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO	Dizzy Spells	☐ YES	☐ NO	Parkinson's Disease	☐ YES	☐ NO
Arthritis (Osteo)	☐ YES	☐ NO	Emphysema	☐ YES	☐ NO	Rheumatoid Arthritis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Fractures	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Cancer:_____	☐ YES	☐ NO	Gallbladder Problems	☐ YES	☐ NO	Speech Problems	☐ YES	☐ NO
Cardiac Conditions	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Stroke(s)	☐ YES	☐ NO
Cardiac Pacemaker	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	Incontinence	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Circulation Problems	☐ YES	☐ NO	Kidney Problems	☐ YES	☐ NO	Vision Problems	☐ YES	☐ NO
Currently Pregnant	☐ YES	☐ NO	Metal Implants	☐ YES	☐ NO			

Please describe any other conditions or precautions:

_____

_____

_____

_____

FALL HISTORY:

Is this injury the result of a fall in the past year? ☐ YES ☐ NO Date of Fall: Month _____ Year _____

Have you had 2 or more falls within the past year? ☐ YES ☐ NO Date of Fall: Month _____ Year _____

Date of Fall: Month _____ Year _____

SURGICAL HISTORY:

Body Region: _____ Surgery Type: _____ Date: Month _____ Year _____

Body Region: _____ Surgery Type: _____ Date: Month _____ Year _____

Body Region: _____ Surgery Type: _____ Date: Month _____ Year _____

CURRENT MEDICATIONS:

Please list all prescription and over the counter medications as well as all supplements taking.
If you have a medications list we would be happy to take a copy in lieu of filling out this section.

Drug: _____ Dosage: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Reason Taking: _____

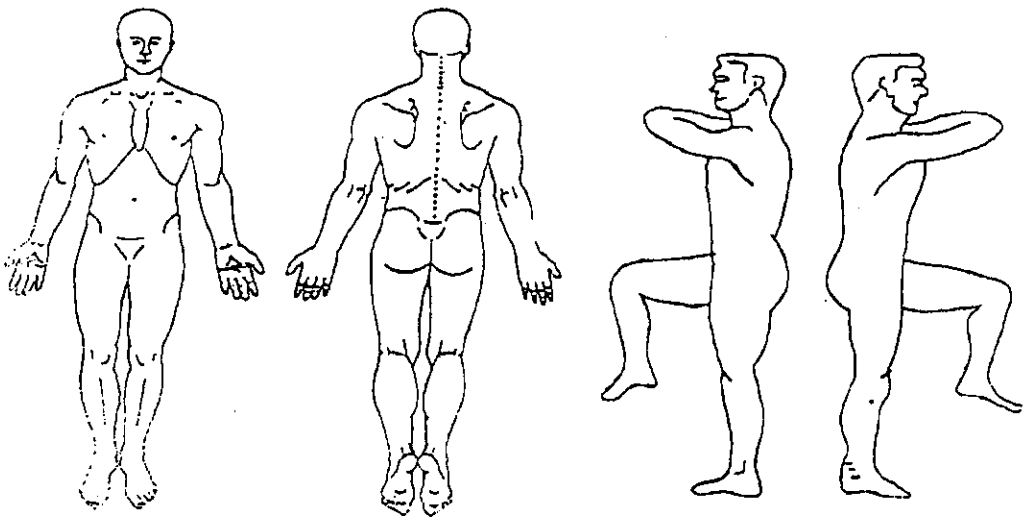
Drug: _____ Dosage: _____ Reason Taking: _____

PAIN CHART

PATIENT NAME: _____ **DATE:** _____

PAIN LOCATION: Please indicate on the body chart below if you are experiencing any of the following:

For PAIN use + + + + For NUMBNESS use o o o o For TINGLING use = = =



PAIN LEVELS: Please CIRCLE the number which best expresses the intensity of your pain with 0 being no pain and 10 being the most severe pain you can imagine.

AT WORST	(none)	0	1	2	3	4	5	6	7	8	9	10 (severe)
CURRENT	(none)	0	1	2	3	4	5	6	7	8	9	10 (severe)
AT BEST	(none)	0	1	2	3	4	5	6	7	8	9	10 (severe)

PAIN TYPE: Please mark all selections below which can be used to describe your pain.

☐ Burning	☐ Sharp	☐ Worse in A.M.	☐ Constant
☐ Throbbing	☐ Shooting	☐ Worse in P.M.	☐ Intermittent
☐ Dull/Achy	☐ Numb/Tingling	☐ Worse at Night	

Sports Therapy and Rehabilitation
303 Fleischmann Way
Carson City, Nevada 89703

Phone: 775-885-7827 ** **Fax 775-885-2301**

RECORDS RELEASE AUTHORIZATION

Please send only the document/s requested. Thank you.

I, _____, hereby authorize the medical facility which performed my procedure, to release the following medical record/s to Sports Therapy and Rehabilitation.

☐ Surgical Report Date of Surgery: _____ Place: _____

☐ MRI Report Date of MRI: _____ Place: _____

☐ X-Ray Report Date of X-Ray: _____ Place: _____

☐ Other: _____

PROHIBITION OF REDISCLOSURE: This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit disclosure of information except with the specific written consent of the person to whom it pertains. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

_____ _____

Signature of Patient (or Authorized Legal Representative) Date Signed

_____

Date of Birth