40 YEARS
KC SPORTS REHAB
PHYSICAL AND HAND THERAPY

PATIENT INFORMATION

Patient's First Name: _____ Middle Initial: _____ Last Name: _____

Patient's DOB: _____ Patient's Age: _____ Social Security Number: _____

(If a minor) Parent/Guardian Name _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Preferred method of contact: ❑ Home ❑ Work ❑ Cell ❑ Email

Gender: ❑ M ❑ F Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Patient's Occupation: _____ Patient's Employer: _____

Emergency Contact: _____ Relationship to patient: _____ Phone: _____

Chief Complaint: _____

Referring Physician and Phone _____

Primary Care Physician and Phone: _____

Is this accident-related? ❑ Yes ❑ No If yes, what was the date of the accident? _____

Was the accident caused by/at: ❑ Work ❑ Auto ❑ Sports ❑ Home ❑ Other

If other, please provide details: _____

If symptoms are not accident-related, please indicate the date of the onset of your symptoms: _____

How did you learn about Sports Rehab? _____

BILLING INFORMATION

Information is same as Patient Information above: ❑ Yes ❑ No If no, please complete this section.

First Name: _____ Last Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer's Phone: _____

Relationship to patient: _____

MEDICAL INSURANCE INFORMATION

Primary Ins. Co.: _____

Group #: _____

Policy #: _____

Insured Name: _____

Employer: _____

Relationship to Patient: _____

Insured Date of Birth: _____

Secondary Ins. Co.: _____

Group #: _____

Policy #: _____

Insured Name: _____

Employer: _____

Relationship to Patient: _____

Insured Date of Birth: _____

If I cannot attend my appointment, I agree to call the office by noon the day before. Failure to do so will result in a **$50.00 cancellation fee** that is not billable to insurance. Payment of fee will be required prior to next visit.

Signature: _____ Date: _____

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MEDICAL HISTORY

Please complete to the best of your ability

Name: _____

Have you **RECENTLY** noted any of the following (check all that apply)?

- ❑ changes in appetite
- ❑ changes in bowel or bladder function
- ❑ difficulty maintaining balance while walking
- ❑ difficulty swallowing
- ❑ dizziness/lightheadedness
- ❑ fever/chills/sweats
- ❑ headaches
- ❑ nausea/vomiting
- ❑ pain at night
- ❑ shortness of breath
- ❑ weakness/fatigue
- ❑ weight loss/gain

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

- ❑ anemia
- ❑ asthma
- ❑ cancer (type)_____
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ diabetes
- ❑ epilepsy
- ❑ lung problems
- ❑ heart disease
- ❑ high blood pressure
  Controlled by meds? YES NO
  Average resting BP _____ / _____
- ❑ pacemaker inserted
- ❑ kidney/liver problems
- ❑ multiple sclerosis
- ❑ osteoporosis
- ❑ Parkinson's disease
- ❑ rheumatoid arthritis
- ❑ stomach ulcers
- ❑ stroke
- ❑ thyroid problems
- ❑ other_____
- ❑ other_____

Due to your injury, have you been feeling down, depressed or hopeless? **YES NO**

Has your injury caused you to have little interest or pleasure in doing things? **YES NO**

Is depression something with which you would like help? **YES YES, but not today NO**

Do you smoke? **YES NO** _____ **pack/day** Do you drink alcohol? **YES NO** _____ **drinks/week**

Age: _____ Height: _____ Weight: _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications: _____ ❑ See Attached

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES: _____

Are you latex sensitive? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized during the past year, including dates:

1. _____ 2._____ 3._____

For the injury you are seeing us for today, please rate your

***Pain at PRESENT**

0 1 2 3 4 5 6 7 8 9 10

No pain — Enough to STOP activity — Worst pain Imaginable

***Pain at WORST,** During THE PAST WEEK.

0 1 2 3 4 5 6 7 8 9 10

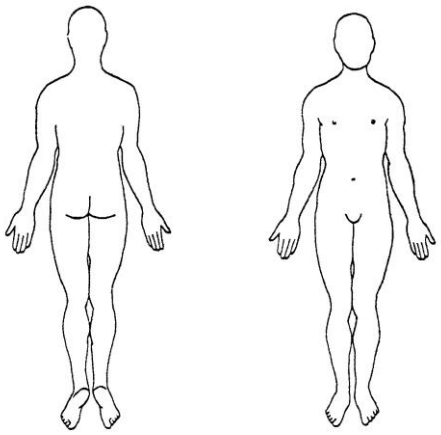
No pain — Enough to STOP activity — Worst pain Imaginable

Body Chart:

Please mark the location of your pain and type of pain on the chart:

Key:

X = sharp/stabbing pain
O = dull/achy pain
… = numb/tingling
//// = throbbing



What is your goal for therapy at this time? _____

Patient Signature: _____ **Date:** _____

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Sports Rehabilitation Physical and Hand Therapy has adopted the following policies which we require that you read and abide by prior to beginning treatment.

Record Release and Assignment of Benefit:

I authorize Sports Rehab the release of all pertinent information necessary regarding my care to physicians involved in my case and/or to insurance companies holding policies on me. I consent to the release of myself or my dependents medical records for the purpose of review or audits to any insurance company, adjustor or attorney involved in the case. I authorize my insurance company to direct payment to Sports Rehab for all therapy services provided and billed. This assignment will remain in effect until revoked by me in writing.

Consent for Treatment:

I consent to allow Sports Rehabilitation Physical and Hand Therapy to provide me with rehabilitation services, which include evaluation, treatment and instruction to assess, prevent and alleviate physical disability and pain. This involves the administration and evaluation of tests, the measurement of bodily function and structures in aid of treatment, the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices for prevention and therapeutic purposes; and the provision of consultative, educational and advisory services for the purpose of reducing the severity and/or incidence of disability and pain.

I hereby authorize Sports Rehab to carry out all procedures as ordered by my physician and permit the clinicians to provide treatments that they judge are beneficial to me. I understand that the clinician will explain the nature of condition and their recommended treatment.

I realize that Physical Therapists and Physical Therapists Assistants in the final stages of their clinical residency and under the direct on-site supervision of a Sports Rehab licensed Physical Therapist or Physical Therapist Assistant, attend to patients. Unless otherwise requested, they may be present during patient care as part of their education.

I also understand that a Physical Therapist's diagnosis is not a medical diagnosis.

This form has been fully explained to me. I understand its content and I agree to all terms and conditions stated above.

Patient services are provided without regard to race, sex, nation of origin, handicap or age. A photocopy of all the above authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Responsible Party DATE

_____ _____

Signature of Authorized Sports Rehab Personnel DATE

_____

Please print patient name

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Financial Policy:

Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost of services you receive from Sports Rehab. **Co-payment is due at the time of service. Co-insurance and/or deductible payments must be made after claims are processed before attending further appointments. If you are unable to pay your balance before your next appointment, you must set up a payment plan policy insuring regular payments towards the balance.**

The patient/guarantor is responsible for providing the front desk staff current insurance cards and correct insured information at the time of initial evaluation, including any required authorization forms. The patient/guarantor is also responsible for informing the clinic of any changes in coverage during the course of treatment.

As the patient, it is your responsibility to verify with your insurance company that Sports Rehab is covered under your plan. As a courtesy, we will verify your benefit information with your insurance company as well as submit patient insurance claims to the insurance carrier(s). We will allow 30 days for your insurance company to pay your claim. After 30 days, payment is your responsibility and should your insurance company process payment at a future date, a refund will be issued. If you do not have insurance, (thus regarded as self-pay), we will be happy to provide care. Charges incurred will be consistent with our usual fee schedule and based on the services provided, with all fees payable at the time of service.

If your delinquent account is turned over to a collection agency by Sports Rehab, it will be at management's discretion to accept you back into the practice. If accepted back, the balance must be paid in full to the collection agency before any future appointments may be scheduled. All future treatment will be on a cash basis only, payable at the time of service. **There is a $50 late fee for cancelations not made by noon the prior day.**

_____ _____

Signature of Responsible Party DATE

_____ _____

Signature of Authorized Sports Rehab Personnel DATE

Credit Card Authorization

Please complete all fields. You may cancel this authorization at any time by contacting us. Authorization will remain in effect until cancelled. Card will be held on file in order to simplify payment of copays and deductibles each visit. You will be notified each time your card is charged.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number to be held on file until discharge : _____ Exp Date : _____ CVC: _____ Zip Code:_____

I,_____, authorize KC Sports Rehab Physical and Hand Therapy to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of providing treatment to you, Sports Rehab must obtain your consent to use and disclose protected health information about you to carry out treatment and health care operations of our office and obtain payment. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. Please refer to the Notice of Privacy Practices for a more complete description of the uses and disclosure that our office staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent form. You may revoke this consent at any time by notifying the office in writing, except to the extent the office has taken action and reliance upon your consent. You have the right to request the office to restrict the manner in which your unprotected health information is used or disclosed to carry out treatment and health care operations and obtain payment. The office is not required however, to agree to such requested restrictions. I hereby consent to the use and disclosure by the office, its workforce and its business associates of my protected health information for the purposes of treatment and health care operations and obtain payment. I acknowledge that I have received a copy of Sports Rehab and Hand Therapy's **Notice of Privacy Practices.**

I authorize _____ who is my _____ to have access to discuss my medical records.
NAME RELATIONSHIP

☐ I give consent to Sports Rehab to leave a message regarding treatment or other information as necessary on voicemail at home or work.

_____ _____
SIGNATURE OF PATIENT DATE