Total Sports Therapy PATIENT REGISTRATION FORM

Patient Information

Please print clearly and sign below

Date:_____

Name (Last) _____ **(First)** _____ (M.I.) ____ (Suffix) _____

Birth Date_____ **Sex**: (M) (F)

Address _____ City _____ State _____ Zip_____

Social Security#_____
If the patient is a minor, please put social security number of the responsible party.

Drivers Lic #_____ (Only required if SS# not supplied)

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ How do you prefer to receive your statements: ❑ E-mail ❑ Fax ❑ Mail

E-mail_____ Fax (____) _____

Employer: _____ Occupation: _____

Address _____ Phone (_____) _____

Referring Physician (if applicable) _____ Telephone _____

Who may we thank for your referral other than your Doctor? _____

Marital Status: Single / Married / Divorced / Widowed / Separated / Domestic Partner / Minor Child

Name of Spouse: _____ Age: _____ Birth date: _____

Spouse Employed by: _____ Occupation: _____ Bus. Phone: _____

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

Emergency Contact _____ Relationship _____ Phone (____) _____

Name and address of closest relative (other than spouse) in case of emergency:

Name: _____ Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

INSURANCE INFORMATION (Please Complete)

Primary Insurance_____ Policy # _____

Insured Name _____ Social Sec# _____D.O.B._____

All professional services rendered are the ultimate responsibility of the patient.

Patient Signature:_____Date:_____

Total Sports Therapy — MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

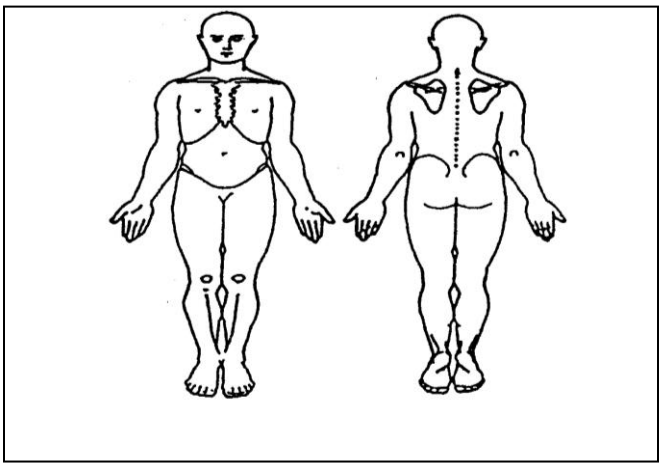
Describe previous treatment for this condition _____

_____

Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Please mark the area(s) of concern

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted:

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain At Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps In Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision Or Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above _____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

_____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals: _____

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

_____ _____

Patient or Personal Representative Signature **Date**

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Total Sports Therapy** to treat the minor patient named in the attached forms while I am not present.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Total Sports Therapy** to furnish Total Sports Therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Total Sports Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

NO-SHOW POLICY: We require at least same day notice in the event of a cancellation. The charge for a no-show without notice prior to scheduled visit is $25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

_____ _____

Patient/Guardian/Responsible Party **Date**

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. All patient balances must be paid within one (1) year of the last date of service. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for an additional 35% due to collection agency costs. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Co-Pay	Co-Insurance
Estimated Co-Pay $_____/visit	**Estimated** Co-Insurance $_____/visit Deductible $_____/year
We will collect your co-pay on the last visit of each week.	We will collect you estimated co -insurance or deductible at the last visit of each week.

The above Financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient/Guardian/Responsible Party **Date**

_____

Clinic Representative **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with out Notice of Privacy Practices (NPP). This **Notice** describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to request corrections to you information;
2. The right to request that your information be restricted;
3. The right to request confidential communications;
4. The right to a report or disclosures of your information; and
5. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This **Notice** contains information about how we will insure that your information remains private. If you have any questions about this **Notice**, the name and phone number of our contact person is listed on this page.

Drew Giardina, Director of Outpatient Physical Therapy
(480) 272-7140

Acknowledgement of Notice of Privacy Practices

" I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**.I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICE** should it be amended, modified, or changed in any way."

Patient or Representative Name (please print)

Patient or Representative Signature Date

☐ Patient Refused to Sign ☐ Patient Was Unable to Sign Because