



# COMMERCIAL INSURANCE Patient & Payor Information Form

**All Patients or Patients' Legal Representative, please complete all Sections**

**( 1 ) Patient: (Full Legal Name or as on Insurance Card )**

**Name:** Last First Initial Sr. Jr.

**Address:** Street Apt# City State Zip Code

**Phone:** ( ) - ( ) - ( ) -  
Home Mobile Work

**Email:** \_\_\_\_\_

**Appointment Reminders** No Yes Please send me ☐ text ☐ email ☐ call notifications to remind me of my appointments at Sports Rehab & Physical Therapy (SRPT) We provide this at no additional cost, however, **YOUR STANDARD MESSAGING RATES MAY APPLY**

**Sex:** M F **Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **S.S #** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Circle one:** Single Married Separated Widow Divorced

**Emergency Contact:** \_\_\_\_\_ ( ) - \_\_\_\_\_  
Name Relationship Phone Number

**( 2 ) Financially Responsible** \_\_\_\_\_ **Initial here** if the person named in Section 1 is financially responsible

**Name:** Last First Initial Sr. Jr.

**Address:** Street Apt# City State Zip Code

**Phone:** ( ) - ( ) - ( ) -  
Home Mobile Work

**S.S #** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**All Patients or Patients' Legal Representative Please Sign Section 5 on Page 2**

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## ( 3 ) Insurance Carrier

Check A or B

A. ☐ Patient is the insured (Do not complete the rest of #3)

B. ☐ Spouse or Parent is the insured (Complete if address is different from patient)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: ( ) - ( ) - ( )  
Home Mobile Work

S.S # / / Birthdate: / / Insured's Sex M F

☐ Employed ☐ Unemployed ☐ Retired Legal ID #

## ( 4 ) Payment Authorization: (Initials required for all 3 statements)

### Assignment of Insurance Benefits

Initials I authorize that the payment of my insurance benefits be made directly to Sports Rehab & Physical Therapy for all services delivered; if I am paid directly I will promptly pay Sports Rehab & Physical Therapy all monies paid to me

### Guarantee of Payment

Initials I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date

### Certification of Information

Initials I certify that the information I have provided Sports Rehab & Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful

## ( 5 ) Signature/ Date:

Patient or Legal Representative's Signature

Today's Date

**All Patients or Patients' Legal Representative Please Sign Section 5 on Page 2**



## AUTHORIZATION FOR RELEASE OF INFORMATION

*Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules*

**(1) Patient's Printed Name:**

\_\_\_\_\_  
Last First Initial or Other

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance # exactly as on card (including letters) \_\_\_\_\_

**(2) Sports Rehab & Physical Therapy will only disclose the protected health information you want disclosed.**

Check only one box to tell Sports Rehab & Physical Therapy the specific information you want disclosed/released:

- ☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)
- ☐ Limited information (complete ALL Sections)
- ☐ ALL records regarding my care at Sports Rehab & Physical Therapy to any requesting party (skip 3 and 4)

**(3) Complete only if you selected "limited information". Please initial all that apply:**

\_\_\_\_ Evaluation/Examination    \_\_\_\_ Attendance    \_\_\_\_ Correspondence re: your Physical Therapy Services  
\_\_\_\_ Past Medical History    \_\_\_\_ Treatments    \_\_\_\_ Other \_\_\_\_\_

**(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:**

Spouse: \_\_\_\_\_ Attorney: \_\_\_\_\_  
Parent: \_\_\_\_\_ Employer: \_\_\_\_\_  
Friend: \_\_\_\_\_ School: \_\_\_\_\_  
Other: \_\_\_\_\_ Other: \_\_\_\_\_

**(5) Check only one box indicating how long Sports Rehab & Physical Therapy can use this authorization:**

- ☐ Disclose my information indefinitely (as long as Sports Rehab & Physical Therapy has custody of my files)
- ☐ Disclose my PHI for the following period beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and ending \_\_\_\_/\_\_\_\_/\_\_\_\_

**(6) Please initial all items below indicating that you have read and understand the rights or information below:**

- \_\_\_\_ I understand that this authorization does not expire unless I have indicated an expiration date above
- \_\_\_\_ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
- \_\_\_\_ I understand that if I give authorization I may revoke it at any time by notifying this Sports Rehab & Physical Therapy in writing
- \_\_\_\_ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
- \_\_\_\_ I understand that if Sports Rehab & Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
- \_\_\_\_ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
- \_\_\_\_ Sports Rehab & Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclosure of purpose & intent

\_\_\_\_\_  
Signature of Patient Date or Signature of Parent or Authorized Representative Date  
(Indicate the Relationship)

***You May Refuse to Sign this Authorization***



## Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

**Potential Benefits:** You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

**Potential Risks:** You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

**Alternatives:** We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

**No Warranty:** Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

**I have read the above information and I consent to the evaluation(s) and treatment provided by Sports Rehab & Physical Therapy**

\_\_\_\_\_  
**Patient's or Authorized Representative's Printed Name & Date**

\_\_\_\_\_  
**Patient's or Authorized Representative's Signature**

## Acknowledgement of Receipt of Notice of Privacy Practices

My signature below indicates that I have been given the Notice of Privacy Practices for Sports Rehab & Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Sports Rehab & Physical Therapy to release any of my protected healthcare information.

\_\_\_\_\_  
**Patient's or Authorized Representative's Printed Name & Date**

\_\_\_\_\_  
**Patient's or Authorized Representative's Signature**

# Physical Therapy Medical Screening Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Gender: M F Pregnant: Y N Smoker: Y N

Occupation: \_\_\_\_\_

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## PAST MEDICAL HISTORY: Please check each condition that you have been told you have or had.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> cancer                                 | <input type="checkbox"/> depression                       | <input type="checkbox"/> thyroid problems   |
| <input type="checkbox"/> heart problems                         | <input type="checkbox"/> lung problems                    | <input type="checkbox"/> diabetes           |
| <input type="checkbox"/> chest pain/angina                      | <input type="checkbox"/> tuberculosis                     | <input type="checkbox"/> osteoporosis       |
| <input type="checkbox"/> high blood pressure                    | <input type="checkbox"/> asthma                           | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> circulation problems                   | <input type="checkbox"/> rheumatoid arthritis             | <input type="checkbox"/> epilepsy           |
| <input type="checkbox"/> blood clots                            | <input type="checkbox"/> other arthritic condition        | <input type="checkbox"/> ulcers             |
| <input type="checkbox"/> stroke                                 | <input type="checkbox"/> bladder/urinary tract infection  | <input type="checkbox"/> liver problems     |
| <input type="checkbox"/> anemia                                 | <input type="checkbox"/> kidney problem/infection         | <input type="checkbox"/> hepatitis          |
| <input type="checkbox"/> bone or joint infection                | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> pneumonia          |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease      | <input type="checkbox"/> pacemaker          |
| <input type="checkbox"/> fibromyalgia                           | <input type="checkbox"/> eye problem/infection            | <input type="checkbox"/> latex allergy      |

**SURGERY HISTORY (Please list all & date):** \_\_\_\_\_

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## MEDICATIONS: Please list all current medications (including pills, injections, skin patches).

**Do you currently take:** NSAIDS or anti-inflammatory medications? Y N Blood thinners? Y N

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## CURRENT SYMPTOMS: Have you recently noted any of the following (check all that apply)?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> fatigue                        | <input type="checkbox"/> numbness or tingling                 | <input type="checkbox"/> constipation        |
| <input type="checkbox"/> fever/chills/sweats            | <input type="checkbox"/> muscle weakness                      | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> nausea/vomiting                | <input type="checkbox"/> dizziness/lightheadedness            | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain               | <input type="checkbox"/> heartburn/indigestion                | <input type="checkbox"/> fainting            |
| <input type="checkbox"/> difficulty maintaining balance | <input type="checkbox"/> difficulty swallowing                | <input type="checkbox"/> cough               |
| <input type="checkbox"/> falls                          | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches           |
|   |   | <input type="checkbox"/> changes in appetite |

Please list any illnesses you have had in the past 3 months: \_\_\_\_\_

During the past month have you been feeling down, depressed or hopeless? Y N

During the past month have you been bothered by having little interest or pleasure in doing things? Y N

Is this something with which you would like help? YES Yes, but not today NO



## CURRENT SYMPTOMS:

Condition to be treated in Physical Therapy: \_\_\_\_\_

What are your current symptoms or pain? \_\_\_\_\_

What **date** (approximately) did your present symptoms start? \_\_\_\_\_

How did your symptoms start (gradual, suddenly, surgery)? \_\_\_\_\_

Is it Related to an Auto Accident? **No Yes** Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Is it Non-Work Related Accident? **No Yes** Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Did this Condition Result in Surgery? **No Yes** If Yes, Date of Surgery \_\_\_\_/\_\_\_\_/\_\_\_\_

Have You Had PT for this Condition? **No Yes** If Yes, Where? \_\_\_\_\_

Are You Currently Receiving any Home Health services? **No Yes** If Yes, Agency's name? \_\_\_\_\_

(SRPT should not provide physical therapy to patients who are having home health services of any kind, not just physical therapy.)

Do You Live in a Nursing Home? **No Yes** If Yes What Is Its Name? \_\_\_\_\_

My symptoms are currently: ☐ Getting better ☐ About the same ☐ Getting worse

How are you able to sleep a night? ☐ Fine ☐ Moderate difficulty ☐ Only with medication

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Please circle the activities which make you symptoms worse:  
lying down                      standing                      walking                      stress                      sitting

Any other activities that make your pain worse? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

Treatment received so far for this problem (chiropractic, injections, etc) \_\_\_\_\_

Please list special tests performed for this problem (x-ray, MRI, labs, etc) \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had this problem before: ☐ Yes ☐ No When \_\_\_\_\_ Treatment rec'd \_\_\_\_\_

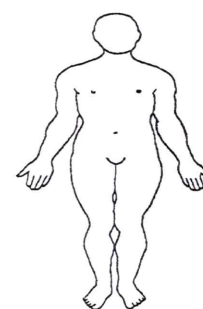
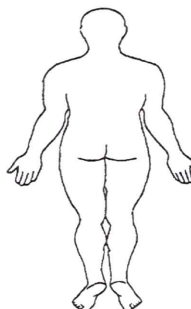
What is your personal goal for therapy? \_\_\_\_\_

## BODY CHART:

Please mark the areas where you feel symptoms or pain on the chart to the right.

### For the therapist

+ / - Cough/Sneeze  
+ / - Saddle Anesth.  
+ / - Bw/Blddr Chnge  
+ / - Numb/Ting.



Using the scales below, please circle the number that best represents the severity of your pain.

At Worst:      No Pain   0   1   2   3   4   5   6   7   8   9   10      Worst Pain Imaginable

Current:      No Pain   0   1   2   3   4   5   6   7   8   9   10      Worst Pain Imaginable

At Best:      No Pain   0   1   2   3   4   5   6   7   8   9   10      Worst Pain Imaginable



How did you hear about us?

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Did a physician refer or recommend you to Sports Rehab & Physical Therapy?

☐ yes ☐ no

What made you choose Sports Rehab & Physical Therapy?

☐ I am a returning patient

☐ It was recommended by a friend or family member

Please tell us who recommended SRPT to you: \_\_\_\_\_

☐ Another healthcare provider recommended SRPT to me

Please tell us the provider that recommended you to SRPT: \_\_\_\_\_

☐ I found Sports Rehab & Physical Therapy through one of the following:

Check all that apply:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> SRPT Website | <input type="checkbox"/> Yelp               |
| <input type="checkbox"/> Facebook     | <input type="checkbox"/> Other Social Media |
| <input type="checkbox"/> Google       | <input type="checkbox"/> Other: _____       |

Thank you, we appreciate your feedback!

“The results you want. The care you deserve.”

Date revised: 7/8/2020