



MEDICARE 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)

Are You Covered:

- | | | | |
|------------------------------|----|-----|---------------------------|
| a. Under Black Lung Disease? | No | Yes | |
| b. End Stage Renal Disease? | No | Yes | |
| c. Large Group Insurance? | No | Yes | If Yes Name/Group # _____ |
| d. Veterans Affairs | No | Yes | |

All Patients or Patients' Legal Representative Please Sign Section 4 on Page 2

(3) 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 SRPT for any services that are reimbursable by Medicare or my any other insurance company, if I have one.

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 the billing statement due date.

Certification of Information

Initials I certify that the information I have provided SRPT for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(4) Signature/ Date:

Patient or Legal Representative's Signature

Today's Date

Notice of Home Health Services

If you have had home health services within six months of being referred to us, we must know so we can verify your discharge from that service. When referred for home health services it will include: Skilled Nursing Services, Occupational Therapy, Physical Therapy, Speech and Language Pathology Services, and Home Health Aide Services (Example: Assistance with basic personal care, meal preparation, feeding, incidental household services light cleaning, treatment of injuries or illnesses or for giving medications/injections, inspecting or inserting feeding tubes, catheters, wound care, etc.) We should know if you are receiving and/or will be receiving home health services of any kind.

Please check mark the following:

☐ I am not receiving home health services of any kind.

☐ I was discharged of all home health services on this date ____/____/____

☐ I am currently receiving home health services.

All Patients or Patients' Legal Representative Please Sign Section 4 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 disclose 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: _____

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

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

SURGERY HISTORY (Please list all & date): _____

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

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

- | | | |
|---|---|--|
| ☐ fatigue | ☐ numbness or tingling | ☐ constipation |
| ☐ fever/chills/sweats | ☐ muscle weakness | ☐ diarrhea |
| ☐ nausea/vomiting | ☐ dizziness/lightheadedness | ☐ shortness of breath |
| ☐ weight loss/gain | ☐ heartburn/indigestion | ☐ fainting |
| ☐ difficulty maintaining balance | ☐ difficulty swallowing | ☐ cough |
| ☐ falls | ☐ changes in bowel or bladder function | ☐ headaches |
| | | ☐ 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 _____

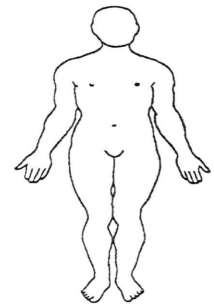
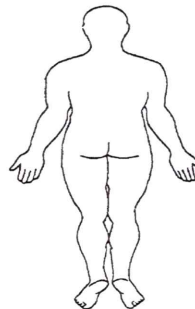
What is your personal goal for therapy? _____

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.
- + / - BwI/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:

☐ SRPT Website ☐ Yelp

☐ Facebook ☐ Other Social Media

☐ Google ☐ Other: _____

Thank you, we appreciate your feedback!

"The results you want. The care you deserve."

Date revised: 7/8/2020