Physical Therapy & Sports Medicine Center

SELF PAY-PATIENT INFORMATION-

SECTION 1: PATIENT DEMOGRAPHICS

Social Security#: ____________-_____________-_____________ Appointment Date:______/_______/_______

Patient Name: ____ Birth Date: _________/__________/___________

Address: ____ Age: _____ Sex:_____ Marital Status: _____

City: _________________________State: _______ Zip: _________

Guarantor Name:____________________________ DOB:___________ Phone: (________)-__________-______________

Email Address: ____ Cell Phone:(_________)-_________-___________

Guarantor Employer: ____ Work Phone:(_________)-_________-__________

Employer's Address: ____

Emergency Contact: ____ Contact Phone: (_______)-_________-___________

Relationship: ____

Primary Care Physician/ PCP: _____________________________ PCP's Phone: (_____)-______-_______

*How did you hear about our facility? __________________________________

SECTION 2: REFERRAL INFORMATION

Name of physician who referred you to physical therapy:____

Referring physician's Phone: (______) - _________-________

SECTION 3 - SELF-PAY PATIENTS

PLEASE INITIAL THIS SECTION IF YOU ARE A SELF-PAY PATIENT.

- ✓ I DO NOT have health insurance. _____________
- ✓ I understand that the PTSMC self-pay charge is $100.00 for the initial evaluation, and also $100.00 per visit, for each visit thereafter.

  ____
- ✓ **I understand that this payment MUST be made AT THE TIME OF SERVICE, at each appointment. NO EXCEPTIONS.**

  ____

SECTION 4 - CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Physical Therapy & Sports Medicine Center to furnish medical treatment, including dry needing treatment, to (please PRINT name)

____

Considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian Signature_______________________________________Date:______________________________

SECTION 5- BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to **which** I am entitled, including Medicare, Medicaid, private insurance and third party payers to Physical Therapy and Sports Medicine Center. A photocopy of assignment is to be considered as valid as the original. I, hereby authorize said assignee to release information necessary including Medical Records to secure payment.

Patient/Guardian Signature_____________________________________Date:__________________________________

Physical Therapy & Sports Medicine Center

SECTION 6

FINANCIAL POLICY AGREEMENT

Please read and initial each of the following and sign and date at the bottom.

Physical Therapy & Sports Medicine Center (PTSMC) will bill your insurance carrier solely as a courtesy to you. Once the explanation of benefits is received by our office, if any outstanding balance and deductible it will be billed and mailed directly to you at the mailing address you provided. You are responsible for the entire bill when the services are rendered.

NOTE: The below does not apply for those patients that are considered Worker's Compensation or PIP/Auto Accident patients. However, be advised if you claim Workers Compensation benefits or receive a settlement based on an auto accident and are subsequently denied such benefits, **patient will** be held responsible for the total amount of charges for services rendered.

_____ Initial — It is the patient's responsibility to pay all co-pays, co-insurance, deductibles, or "cash pay" estimated amounts at the time of service.

_____ Initial — The patient agrees to assign all medical benefits to PTSMC for services provided. If any payment by patient's insurance company is made directly to patient for services billed by PTSMC, patient recognizes an obligation to promptly remit same to PTSMC.

_____ Initial — If for any reason the insurance company does not pay for the covered services provided within 60days, the patient shall assume responsibility for the total amount owed.

_____ Initial — It is the patient's responsibility to pay all uncovered services and balances within 30 days of receiving their financial statement.

_____ Initial — Patients who have a previous balance and wish to receive additional services are required to pay all previous balances in full prior to time of service.

_____ Initial — In the event that patient's insurance company requests a refund of payments made, patient will be responsible for the amount of money refunded to patient's insurance company.

_____ Initial — Patient has been advised that if the patient fails to make any of the payments for which the patient is responsible in a timely manner, the patient will be responsible for all costs of collecting monies owed, including the recovery of court costs, collection fees and attorney fees (If applicable), as well as interest of 10% owed on any outstanding balances, and the patient will be discharged from treatment for non-compliance.

_____ Initial — Returned checks will result in a $40.00 Service Charge.

_____ Initial — Patient understands in the event a payment is made via credit card, and a refund is required. Payment will be refunded **ONLY** to the credit card originally used, please allow 15 days to process. If payment was made with cash or check the refund will be issued by check, please allow 30 days to process refund.

I have read the above information and certify that I understand and will abide by the above policies set forth by Physical Therapy and Sports Medicine Center.

______________________________	______________________
Patient/Guardian Name (please print)	Date
______________________________	______________________
Patient/Guardian Signature (parent or legal guardian if minor)	Witness Name (Front Desk PTSMC

SECTION 7

Patient Authorization and Disclosure of Protected Health Information Statement of Privacy Act.

We may disclose your health care information:

1. To other healthcare professionals within our practice for the purpose of treatment, payment or health care operations.
2. To insurance provider for the purpose of payment or health care operations.
3. To comply with State Workers' Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative of judicial proceeding or law enforcement purposes

Under HIPPA Federal Privacy law, you have the right to:

1. Request restrictions on certain uses of your health care information
2. Inspect and copy your healthcare information
3. Receive an accounting or disclosures of your protected health information made by us.
4. You have a right to a paper copy of this Notice of Privacy Practices at any time, upon request.

We reserve the right to amend this notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your healthcare information.

If you have any questions regarding this notice or if you want more information about your privacy rights, please contact us at 301.446.1644.

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse____
[ ] Child(ren)______________________________________
[ ] Other____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

My signature indicates my authorization and consent for Physical Therapy and Sports Medicine Center to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described above.

Patient's Name (PRINT): ____

Patient/Guardian Signature: ______________________________Date: _______________

SECTION 8

Cancellation and No-Show Policy

- We ask that you help us to serve you by keeping your scheduled appointment. Appointments that are missed or cancelled at the last minute are not able to be given to other patients who need an appointment.
- You must be on time, so that you can be given the full benefit of your therapy session.
- Any patient who arrives more than 15 minutes late may not be seen by the therapist, AND a **cancellation charge of $50.00** will be applied. If a patient is running late, it is asked that you call our office and let us know so that we can inform the therapist.
- **PT&SMC requires at least 24 hours-notice for appointment cancellation. Any appointment that is cancelled the same day or within less than 24 hours will result in a $50.00 cancellation fee**.
- **This fee must be paid before one can be checked in at the next appointment.**
- **No-shows are a $50 charge**
- **Understand that if you do not show up to an appointment, without notice to our office, any future scheduled appointments will be removed from the system. The $50 fee must be paid in order for the next appointment to be scheduled.**
- **Three episodes of not attending physical therapy (no-show) will result in patient discharge from therapy.**
- **In the case of medical emergency, proper documentation (doctor's note etc.) must be provided.**

Non-Compliance Clause

- Any patient who has 3 consecutive appointment cancellations or no-shows, will be discharged from physical therapy for non-compliance and your referring physician will be notified. It is important for you to stick to the prescribed treatment plan in order for it to be as effective as possible.

The above information has been read and explained to me. I understand this office policy.

Patient/Guardian Signature: ____Date_________________________________

Physical Therapy & Sports Medicine Center

SECTION 9

Email and Text Messaging Program Consent Form

Patient Name: ____

We are happy to provide our patients with the option to participate in our online patient communication system.

Some of the features include the ability to:

1. Request appointments via website
2. Confirm appointments via text message
3. Receive text/email/voice message appointment reminders
4. Submit patient satisfaction surveys
5. Receive PTSMC communication via text/email(i.e. newsletter, announcements, updates and promotions

Please select **ONE** of the following methods you wish to be reminded of your appointment:

- ☐ **TEXT ME AT THIS CELL # ______________________**

  OR

- ☐ **LEAVE ME A VOICE REMINDER AT THIS NUMBER____________________**

You may choose to discontinue your participation in our online communication system at any time simply by clicking the "unsubscribe" link found at the bottom of each email, or by replying "STOP" to a text message from us. Standard text messaging rates may apply.
We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

____

Patient/Guardian Signature Date

Physical Therapy & Sports Medicine Center

PATIENT MEDICAL HISTORY

Patient's Name____ Date of Birth _____/______/____ Age: ______

Date of Injury or accident___/___/____ Height: ________ Weight: ________

Have you had surgery for this injury? YES NO (If yes, Number of Surgeries____)

Are you currently taking any Prescription or Non- Prescription Medication? YES NO

If yes, fill out the attached Medication List.

Have you had any of the following Medical or Rehabilitation services for this injury YES NO

	YES	NO		YES	NO
Chiropractor	____	____	Occupacional Therapy	_____	_____
EMG/NVC	____	____	Orthopedic	_____	_____
Massage Therapy	____	____	Physical Therapy	_____	_____
Myelogram	____	____	Podiatrist	_____	_____
ER CARE	____	____	X Rays	_____	_____
CT SCAN	____	____	MRI	_____	_____
Gen Prac.	____	____			
Neurologist	____	____			

____

Do you now or have you ever had any of the Following?-

	YES	NO		YES	NO
Asthma, Bronchitis, or emphysema	_____	______	Severe or Frequent Headaches	____	_____
Shortness of Breath/Chest Pain	_____	______	Vision or Hearing Dificulties	____	_____
Coronary Heart Disease or Angina	_____	______	Numbness or Tingling	____	_____
Do you have a Pacemaker?	_____	______	Dizziness or Fainting	____	_____
High Blood Pressure	_____	_______	Hernia	______	_____
Heart Attack/Surgery	_____	_______	Blood Clot/Emboli	_____	_____
Stroke/ TIA	_____	_______	Veracose Veins	_____	______
Bowel or Bladder Problems	______	______	Allergies	_____	______
Epilepsy/Seizures	______	_______	Pins or Metal Implants	______	_______
Thyroid Trouble/Goiter	______	_______	Joint Replacement	______	_______
Anemia	______	_______	Diabetes	______	_______
Infectious Disease	______	_______	Cancer or Chemotherapy	______	______
Emotional/Psychological Problems	______	_______	Osteoporosis	______	_______
Arthritis/Swollen Joints	______	_______	Are you Pregnant?	______	_______
Gout	______	_______	Do you Smoke?	______	_______
Difficulty or unable to sleep	______	_______	Elbow/Hand/Shoulder Surgery	______	_______
Leg/ankle/knee/foot Surgery	______	_______	Weakness	______	_______
Back/Neck/Surgery	_______	_______			
Have you had any falls in the last year?	_______	_______			

Are you aware of your Diagnosis? YES NO

Based on your awareness, what are your expectations/goals while in this program?

____

SIGNATURE: _______________________________________ DATE: ______/_______/______

Physical Therapy & Sports Medicine Center

Draw the Location of your pain on the body outlines and circle the pain face that applies:

Pain	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^^	* * * *	∞∞∞∞	....	///////	XXX

FRONT **BACK**

SIGNATURE: ____ DATE: ______/_______/______

RIGHT LEFT LEFT RIGHT

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Possible

SIGNATURE: ____ DATE: ______/_______/______

Medication List

Name: ______________________________________ Date: ________________________________

Medication	Dosage	Frequency	Route of Administration