



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 needling 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: _____



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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.

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

_____ The patient agrees to assign all medical benefits to PTSMC for services provided. If any
Initial 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.

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

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

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

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

_____ Patient has been advised that if the patient fails to make any of the payments for which the patient
Initial 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.

_____ 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
Initial **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)



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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 or 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: _____



Physical Therapy & Sports Medicine Center

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 _____



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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



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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	_____	_____	Occupational 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 Difficulties	_____	_____
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	_____	_____	Varicose 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: ____/____/____

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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: ____/____/____



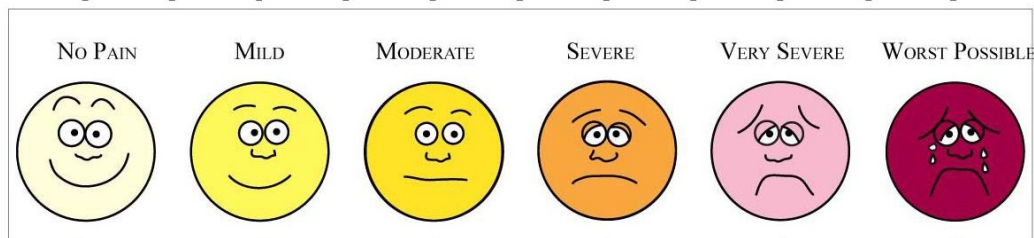
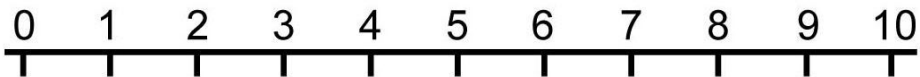
RIGHT

LEFT



LEFT

RIGHT



SIGNATURE: _____

DATE: ____/____/____

