## PATIENT INFORMATION

Patient Name: _____ Email: _____

Mailing Address: _____ Home Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Date of Birth: ___ / ____ / _____ Social Security Number: _____ - ____ - _____

Marital Status: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

Patient Relationship to Resp. Party: (circle one) SELF SPOUSE CHILD OTHER

Sex: (circle one) MALE FEMALE

Primary Care Physicians: _____ Referred By: _____

PATIENT'S EMPLOYER INFORMATION

Company: _____ City: _____

Supervisor: _____ Phone: _____

ACCIDENT INFORMATION

Date of Injury: _____ Work Related: _____ Auto: _____ Other: _____ State: _____

## COMMUNICATION

Best method for us to contact you: (circle one) Cell Phone Work Phone Home Phone

Is it ok to leave a message or voice mail: YES NO Please specify phone #: _____

Do you authorize us to speak with anyone else regarding your care: YES NO

Please name individuals we are authorized to speak with regarding your care:

Name: _____ Phone #: _____ Relationship: _____

## RESPONSIBLE (OR INSURED) PARTY INFORMATION

Resp. Party Name: _____

Address: _____

Date of Birth: _____ / _____ / _____ Sex: (circle one) MALE FEMALE

Home Phone #: _____ Work Phone #: _____

Social Security Number: _____ - _____ - _____ Employer: _____

## INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____ Phone: _____

Contract/ ID #: _____ Subscriber Name: _____

Patient Relationship to Subscriber: (circle one) SELF SPOUSE CHILD OTHER

Group Name: _____ Group Number: _____

Insured's Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

**The Point**
SPORTS MEDICINE AND REHAB

Revised 6/2014

**WE APPRECIATE THE OPPORTUNITY OF SEEING YOU.**
**WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.**

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IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____
Phone number(s): _____
Relationship: _____
Address: _____

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# CONSENT FOR THERAPY SERVICES

I, _____, hereby consent to therapy services and authorize therapists and trained staff to evaluate, examine, and treat my condition. I furthermore authorize use of any devise that may be therapeutically beneficial to my condition. I understand there is no guarantee as to the results of the therapy. I understand it is my responsibility to complete my home programs and failure to do so may adversely affect the outcome of my therapy.

I authorize The Point Sports Medicine and Rehabilitation Clinic to release medical records to my physician, insurance company, and other professionals deemed necessary.

I authorize The Point Sports Medicine and Rehabilitation Clinic to request and receive medical records from physicians, insurance companies, and other professionals deemed necessary. I understand that I may revoke the consent at any time by written notice and a copy of this is valid as original.

I will notify The Point 24 hours prior to my scheduled appointment if I need to cancel or I am going to be later than the scheduled appointment time.

The use of The Point facilities will be allowed only in a manner prescribed by the treating therapist. I understand and assume all risks that may occur through the use of The Point.

I have read this consent and billing agreement. I understand and agree to all of the above information.

**Patient's Signature:** _____ **Date:** _____

**Legal Guardian's Signature:** _____ **Date:** _____

**Witness' Signature:** _____ **Date:** _____

# BILLING AGREEMENT

The Point Sports Medicine and Rehab is happy to verify your insurance benefits for physical therapy services. Please be advised that the benefits provided to us are ***estimates only*** and may change depending on your insurance policy. The Point will send patient statements after an explanation of benefits (EOB) is received from the insurance company. If a response is not received from the insurance company within 90 days a patient statement will be generated. The Point has no control over when the insurance company will respond, so patient statements may be delayed. Please be aware insurance companies send information about your bill to your home.

- It is my responsibility to know the requirements of my insurance policy and follow guidelines.
- I understand that my insurance policy may require a referral from my primary care physician for therapy. I understand it is my responsibility to see that the referral is in effect prior to starting therapy, as well as any additional referrals, which are in accordance with my insurance policy requirements.
- I understand that pre-authorization for therapy by The Point staff is not a guarantee of benefits and/or payment by my insurance company. Any outstanding charges on my bill after insurance payments will be my responsibility.
- I agree to make co-payments, percentages payments, and/or deductible payments at the time of services. I agree to inform The Point of any policy changes. Payment will be due on date of service, prior to services rendered.
- I agree to pay the balance of my bill.
- I agree to provide my insurance carrier with any information they require in order to process my claim in a timely manner. If the requested insurance information is not sent within 14 days, the claim will be considered the patient's or legal guardian's responsibility.
- I understand that if this is an accepted workers' compensation claim I will not be billed. If the claim is denied by the workers' compensation carrier I will be responsible for the balance.
- I authorize The Point to bill my insurance for any supplies or DME which may be used or issued to me during my rehabilitation. I understand that any single piece of supply/DME valued over $25.00 will require prescription from my physician and must be preauthorized by my insurance carrier. I understand preauthorization for supplies/DME by The Point is not a guarantee of benefits and/or payment by the insurance carrier. Any items or costs that are not fully covered by insurance will be my financial responsibility.

I have read this billing agreement. I understand and agree to all of the above information.

**Patient Name**_____ **Date:**_____

**Patient/Legal Guardian's Signature:** _____ **Date:** _____

**Witness' Signature:** _____ **Date:** _____

The Point
SPORTS MEDICINE AND REHAB

Revised 9/26/12

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that The Point Sports Medicine & Rehabilitation Clinic, Inc. may share my health information for treatment, billing, and healthcare operations.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that The Point Sports Medicine & Rehabilitation Clinic, Inc. has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

** Please ask the receptionist for a copy of the *Notice of Privacy Practices* if you wish to have a copy of your own. Otherwise a copy is provided at the front desk to read.

**Patient's Name:**____ _____ **Date:** _____

**Patient/ Legal Guardian's Signature:** _____

**Relationship to Patient (circle one):** **Self** **Spouse** **Parent/Guardian** **Other** _____

The Point
SPORTS MEDICINE AND REHAB

## MEDICAL HISTORY

| | | Please list dates/ describe: |
|---|---|---|
| Cancer/Tumor | ☐ Yes ☐ No | |
| Diabetes | ☐ Yes ☐ No | |
| High Blood Pressure | ☐ Yes ☐ No | |
| Heart Disease | ☐ Yes ☐ No | |
| Angina/Chest Pain | ☐ Yes ☐ No | |
| Stroke | ☐ Yes ☐ No | |
| Blood Clots | ☐ Yes ☐ No | |
| Lung Disease | ☐ Yes ☐ No | |
| Shortness of Breath | ☐ Yes ☐ No | |
| Hernia | ☐ Yes ☐ No | |
| Osteoporosis | ☐ Yes ☐ No | |
| Rheumatoid Arthritis | ☐ Yes ☐ No | |
| Osteoarthritis | ☐ Yes ☐ No | |
| Asthma/Allergies | ☐ Yes ☐ No | |
| Anemia | ☐ Yes ☐ No | |
| Neurological Disorder | ☐ Yes ☐ No | |
| Dizzy/Light Headedness | ☐ Yes ☐ No | |
| Seizures | ☐ Yes ☐ No | |
| Hepatitis | ☐ Yes ☐ No | |
| Do you have a pacemaker? | ☐ Yes ☐ No | |
| Recent Hospitalization | ☐ Yes ☐ No | |
| Recent Illness | ☐ Yes ☐ No | |

**Allergies:**

Latex ☐ Yes ☐ No
Tape/Adhesive ☐ Yes ☐ No
Drugs/Medications: ☐ Yes ☐ No
Please list: _____

**Female Only**

Are you currently pregnant? ☐ Yes ☐ No
Expected due date: _____

## THE PAIN SCALE

*Please DO NOT Exaggerate Your Pain*

| | |
|---|---|
| 10+ | My Maximum Pain Possible. I should be hospitalized |
| 10 | Excruciating Pain. I need to go to the Emergency Room. |
| 9 | Very, Very Strong Pain. I'm considering the Emergency Room. |
| 8 | Very Strong Pain |
| 7 | Very Strong Pain |
| 6 | Very Strong Pain |
| 5 | Strong Pain |
| 4 | Somewhat Strong Pain |
| 3 | Moderate Pain |
| 2 | Weak Pain |
| 1 | Very Weak Pain |
| 0.5 | Very, Very Weak Pain |
| 0 | No Pain at All – Normal |

Instructions: Indicate what your pain is *right now*, and your *lowest* and *highest pain* over the last 30 days/or since your injury occurred, by writing a number on the lines below "The Pain Scale"

Please Write Your Pain Number On The Lines Below!

1. What is your pain RIGHT NOW? _____
2. Your LOWEST PAIN over the last 30 days, or since your injury? _____
3. Your HIGHEST PAIN over the last 30 days, or since your injury? _____

# The Point
## SPORTS MEDICINE AND REHAB

**Name:** _____ Date: _____
Date of Birth: _____

Describe the problem you are coming in for: _____
_____
_____

**Referring Doctor:** _____
When did this problem start? _____
Have you had surgery for this? ☐ Yes ☐ No
If so, when was your surgery? _____
Previous Treatment for current condition: _____
_____

**Current Occupation:** _____
Are you currently working? ☐ Yes ☐ No
Job Description: _____
List Physical Job Duties: _____
_____

List the activities that you are having difficulty or discomfort with because of your injury: (such as walking, standing, sitting, sleeping, personal hygiene, housework, sports, yard work, recreational activities, etc.)

1. _____ Level of Discomfort: 1 2 3 4 5 6 7 8 9 10 (1=minimal – 10=worst)
2. _____ Level of Discomfort: 1 2 3 4 5 6 7 8 9 10 (1=minimal – 10=worst)
3. _____ Level of Discomfort: 1 2 3 4 5 6 7 8 9 10 (1=minimal – 10=worst)
4. _____ Level of Discomfort: 1 2 3 4 5 6 7 8 9 10 (1=minimal – 10=worst)
5. _____ Level of Discomfort: 1 2 3 4 5 6 7 8 9 10 (1=minimal – 10=worst)

What are your goals/expectations from therapy? (Please try to be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any medication you are currently taking (including non-prescription): _____
_____
_____
_____

**Surgeries, broken bones, or other significant injuries:**

| Date: | Surgery/Injury: |
|---|---|
| | |
| | |
| | |
| | |
| | |