SPORTS & MORE PHYSICAL THERAPY, INC.

Revised 1/1/2020

Patient Intake Information

Today's Date _____

Full Name: _____
Last First Middle Suffix Nickname

Address: _____
Street Address or Box City State Zip

Phone: _____
Home Work Cell
(Please include area code. Please indicate best number to reach you during business hours with an *

Patient Info: _____ ☐ **Part-time student** ☐ **Full-time student**
Date of Birth Age Social Security # Employed

☐ **Male** ☐ **Female** ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Emergency Contact: _____ **Relationship** _____
Name Daytime phone #

Patient's Email : _____

Would you like for us to email you reminders for your follow up appointments? ☐ **yes** ☐ **no**

Would you like for us to text you reminders for your follow up appointments? ☐ **yes** ☐ **no**

If patient is a minor: _____
Parent/Guardian's: Name Best phone number to call Email

INSURANCE/PAYMENT INFORMATION - Please provide insurance card and ID to our admin staff.

Primary Policyholder:

_____
Name Date of Birth SS# Relationship to Patient

Is this an HSA or HRA account? ☐ **Yes** ☐ **No** **If yes, which is it?** ☐ **HSA** ☐ **HRA**

Responsible Party - Name _____ **Relationship to Patient** _____
(Person who is responsible for patient's portion of payment due)

PLEASE DO NOT SIGN BELOW THIS LINE UNLESS YOU HAVE BEEN HERE FOR A NEW EVALUATION DURING THIS CALENDAR YEAR.

Please review the information above. Correct and/or sign below indicating that the above information is up-to-date and correct..

_____ **Date** _____
Patient or parent signature

Please review the information above. Correct and/or sign below indicating that the above information is up-to-date and correct..

_____ **Date** _____
Patient or parent signature

Patient Intake Information – Page 2

Today's Date _____

Description of Problem for which you are being seen today: _____
Problem Area(s) (Please be specific – right/left/both)_____

_____

Referring Physician/Provider: _____ **Type of Surgery** _____**Surgery date?**_____

Is your treatment here a result of an injury? ☐ **Yes** ☐ **No** **If yes, date of injury:** _____
Type of Injury: ☐ **Work** ☐ **Auto** ☐ **Other** **Mo/Day/Year**

Do you plan to file Worker's Compensation? ☐ **Yes** ☐ **No** **Claim #** _____

If yes, give employer's name: _____ **Adjuster's name:** _____
Who should we call to verify?_____
Name and phone number (with area code).

AGREEMENT & AUTHORIZATION – Please initial each line.

_____**I hereby authorize Sports & More Physical Therapy, Inc. to perform all necessary physical therapy treatments deemed appropriate by the evaluating physical therapist for my condition and/or recommended by my physician.**

_____**I understand that if services provided by Sports & More Physical Therapy, Inc. are not authorized by my insurance company or Worker's Compensation I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered.**

_____ **I understand that my insurance benefits will be verified by a Front Office Staff Member of Sports & More Physical Therapy, Inc. prior to my first appointment and reviewed with me. I also understand that verification of benefits and/or confirmation of authorization DO NOT guarantee payment by my insurance and that eligibility and benefit determination will be made once the insurance claim is received and processed by my insurance company.**

_____ **I hereby authorize and request my referring or physician or health care provider to release to Sports & More Physical Therapy, Inc. pertinent medical records.**

_____ **Sports & More Physical Therapy, Inc. is authorized to release to my insurance company, attorney(if applicable), or adjuster (if applicable) any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Sports & More Physical Therapy, Inc. is also authorized to release medical information to my referring physician or health care provider to monitor progress.**

_____ **I hereby authorize and direct my insurance company or companies to make direct payment to Sports& More Physical Therapy, Inc. under any and all applicable coverage, including major medical, for covered charges for services rendered.**

_____ **I have been given an opportunity to review the Notice of Patient Information Practices, Rights and Responsibilities for Sports & More Physical Therapy, Inc. (as required and updated by the HIPAA on November 1, 2013).**

_____ **I authorize Sports & More Physical Therapy or a designated representative to contact me or any person named on the Patient Consent Form and leave messages regarding appointments, account balances, or clinical questions by calling any telephone number provided on this form.**

_____ **I have been given a copy of the Patient Orientation Form for Sports & More Physical Therapy, Inc.**

_____ **I understand that there is a $50 Missed Appointment Charge for any appointment that is missed or cancelled in less than 24 hours previous to appointment time.**

_____ _____ _____
Patient Name (*please print*) **Parent/Guardian (Print)** **Date**

_____ _____ _____
Patient Signature **Parent/Guardian Signature** **Witness**

SPORTS & MORE PHYSICAL THERAPY, INC Partnered with: ACCESS PHYSICAL THERAPY & WELLNESS™ Preferred by Patients, Trusted by Physicians

No Show and Cancellation Policy

Scheduled appointment times are very important at Sports & More Physical Therapy partnered with Access PT & Wellness. It is our policy to make sure you are not waiting more than 5 minutes for your scheduled appointment. In return, we ask that you make every effort to be on time for your appointment. If you are unable to keep an appointment, we ask that you give us at least 24 hours' notice. The following no show and cancellation policy is in effect:

No Show Policy: If an appointment is missed without a notifying phone call with 24 hours' notice, a $50 fee will be charged (this is **not** covered by your insurance). If this occurs a second time, not only will a fee be incurred, but we reserve the right to place you on our "call the day of" list or discharge you from our services.

Cancellation Policy: If an appointment is cancelled with less than 24 hours notice given, we reserve the right to charge a $50 fee (this is **not** covered by your insurance). If this appointment is **rescheduled** for another time that day or another time that week the fee will not be incurred. If 3 cancellations occur you will be placed on our "call the day of" list or you may be discharged from our services.
*We understand emergencies can happen. The therapist will use their discretion to accommodate these unforeseen circumstances.

If you know your personal or work schedule will cause you to cancel several appointments with short notice and you do not want to incur fees, you have the following options:

Schedule appointments for full plan of care *so that you can reserve the time that is most convenient for you and your schedule.*
Reschedule *your appointment for another time that day or that week. We will do our utmost best to accommodate your desired time.*
"Call the day of" *If you know on a particular day that you will be able to make an appointment, you can call first thing in the morning and see what we have available that day*

I _____have read and understand the cancellation policy.
(please print name)

_____ _____
Signature Date