SPORTS & MORE
PHYSICAL THERAPY, INC.

Revised 2/23/17

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)

DO NOT SIGN BELOW UNLESS YOU ARE A RETURNING PATIENT.

***If you are a returning patient please review the information above and if there are no changes please sign below indicating that the above information is up-to-date and correct..**

______________________________________ Date ______________________________
Patient or parent signature

***If you are a returning patient please review the information above and if there are no changes please 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 <u>verification of benefits and/or confirmation of authorization DO NOT guarantee payment</u> 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 <u>referring</u> 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 $25 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**