Patient Information

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Cancelation/No Show Fee Policy & Acknowledgement of Privacy Practices

We strive to provide our patients with the utmost professionalism, excellence of service and the guarantee of privacy as mandated by section 164.520 of the HIPAA Privacy Rule (copy located at the front desk). Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

We expect you to keep all your appointments. We will provide you with a printout of your appointment dates and times. We reserve the right to discontinue care and will inform your physician that your services have been discontinued due to non-compliance with the prescribed rehabilitation order.

If you need to cancel your appointment, we require 24-hour notice. **If you do not provide appropriate cancellation notice or no-show your appointment, you will be subject to our $35 cancellation fee. For 1 hour appointments, the charge is $65.**

If you miss (2) *additional* appointments (a total of three (3) appointments) without 24-hour notice, your future appointments will be canceled, and you will need to contact our office to make arrangements for additional appointments with the Front Desk Receptionist. If Cancelation/No-Show Fee has not been paid by a month of date missed, there will be a $10 late fee applied to the original $35 for every month the payment is not received.

We are obligated to communicate any instances of non-compliance to your referring doctor.

X_____ _____
Signature of patient or responsible party Date

Release of Information and Authorizations

The undersigned authorizes & directs Sports Rehab Physical Therapy, having treated the patient, to release to governmental agencies, insurance carriers, or others who are financially liable for my physical therapy treatment, any medical record or other information pertinent to my physical therapy treatment. Additionally, I consent to the use of my name, email and date of birth in creation of a Medbridge account, in order to access exercises and/or educational material relevant to my physical therapy care.

I am responsible for all financial obligations of health services for the above patient, for reimbursement and payment of all claims from my insurance company. I authorize the insurance carrier to pay Sports Rehab Physical Therapy directly, in accordance with the California State prompt pay law for these services. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection costs, and reasonable legal fees incurred in the collection of this account.

X_____ _____
Signature of patient or responsible party Date

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Patient Financial Responsibility Form

Thank you for choosing Sports Rehab Physical Therapy as your rehab provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INSURANCE COVERAGE: It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours. We will bill your insurance provider as a courtesy.

INSURANCE CHANGES: If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS:

• Coinsurance and copayments are the patient's responsibility. Copays are due at every visit.

• Deductibles are the patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.

REFERRALS: It is your responsibility to obtain referrals if required to do so by your plan. We will assist you in obtaining the referral as needed. If your Primary Care physician changes you must notify us immediately and obtain a new referral.

NON-COVERED SERVICE: All patients are responsible for "non-covered" services if denied by their insurance carrier. We emphasize that as a medical care provider, our relationship is with you and not with your insurance company. It is your responsibility to know your policy. Again, we thank you for choosing Sports Rehab Physical Therapy as your healthcare provider and are here to help you!

I have read and understand this financial responsibility form.

_____ _____
Patient Name (printed) Date of Birth

X_____ _____
Patient Signature Date

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*Patient Name: _____ *DOB: _____ *SS#: _____

If under 18, Responsible Party Name: _____ DOB: _____

*Address: _____

(House Number and Street) (City) (State) (Zip Code)

*Primary Phone: _____ ☐ Cell ☐ Home

Secondary Phone: _____ ☐ Cell ☐ Home

Email: _____ Pronouns: _____

Appointment Reminders:		
Primary	**OR**	Secondary
☐ Call		☐ Call
☐ Text		☐ Text

Occupation: _____

*Is this a Worker's Comp Claim? ☐ Yes ☐ No

If Yes: Employer's Address: _____ Phone #: _____

*Is this the result of a Car Accident? ☐ Yes ☐ No

*Have you been covered under Home Healthcare? ☐ Yes ☐ No If yes, date discharged: _____

*Primary Insurance: _____ Subscriber's Name: _____

DOB: _____ SS# _____ Subscriber ID #: _____

Relationship to patient: _____

*Secondary Insurance: _____ Subscriber's Name: _____

DOB: _____ SS# _____ Subscriber ID #: _____

Relationship to patient: _____

To whom do you authorize us to disclose your personal health information?

Name: _____ Phone: _____ Relationship to Patient: _____

*Have you ever previously been a patient at Sports Rehab? ☐ Yes ☐ No

X_____ _____

Patient Signature Date

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Patient Name: _____

Have you ever been diagnosed with any of the following (Yes / No)?

Y / N Type 1 Diabetes or Type 2 Diabetes	**Y / N** Obesity
Y / N High or low blood pressure Medicated? **Y / N**	**Y / N** Heart disease (angina, arrhythmia, heart failure, etc.)
Y / N Hearing or vision impairment	**Y / N** Osteoarthritis
Y / N Dizziness or vertigo	**Y / N** Rheumatoid arthritis
Y / N Anxiety and/or depression	**Y / N** Osteopenia or osteoporosis
Y / N Thyroid dysfunction (high or low)	**Y / N** Stroke
Y / N Other autoimmune disease _____	**Y / N** Cancer If **yes**, when?: _____
Y / N Asthma	**Y / N** Kidney problems
Y / N Other lung problems (infection, pneumonia, COPD, bronchitis, emphysema, etc.)	**Y / N** Infectious Disease (Hepatitis, Tuberculosis, HIV/AIDS)
Y / N Developmental or growth problems	**Y / N** Seizures/Epilepsy
List all current medications, or provide separate list:	**List all past surgeries, with the year:**
List all allergies, or provide separate list:	**Please write anything else that you think is important for us to know:**

How would you rate your overall, general health? ⚪ Excellent ⚪ Very Good ⚪ Good ⚪ Fair ⚪ Poor

Do you smoke? ⚪ Yes ⚪ No
Do you drink alcohol? ⚪ Yes ⚪ No
Are you currently pregnant? ⚪ Yes ⚪ No

How many days per week do you exercise? _____

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Patient Health Questionnaire

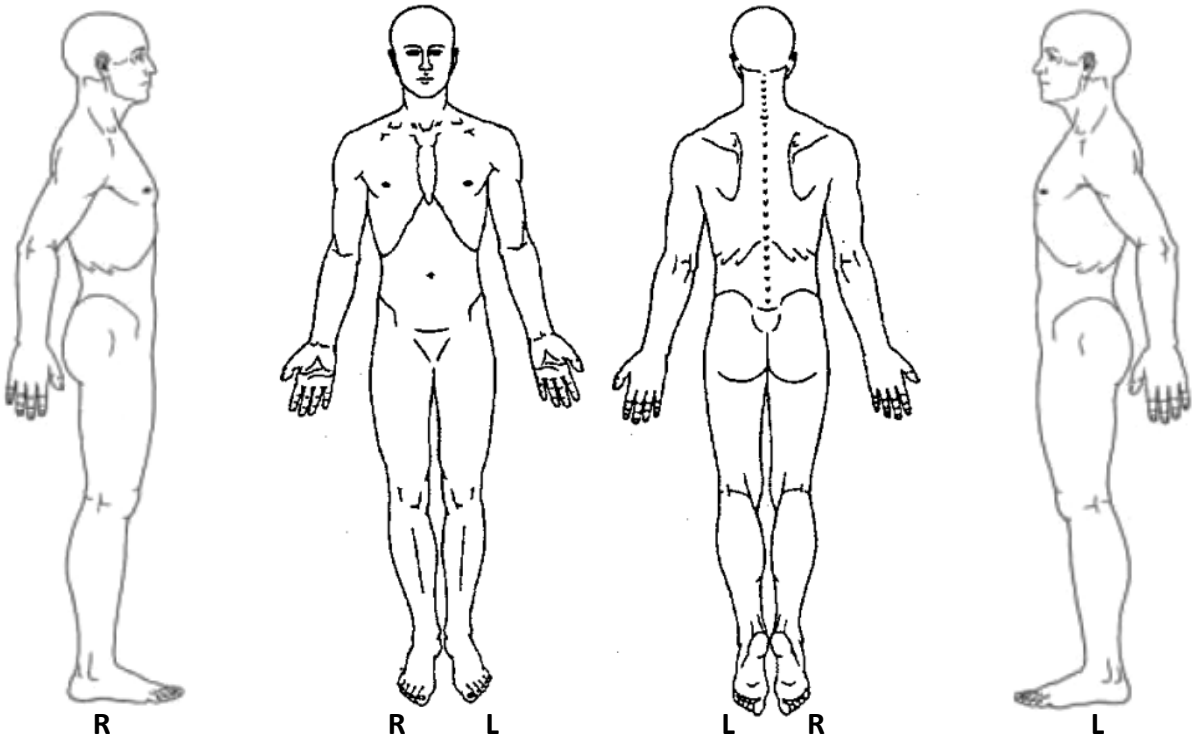
How often do you experience your symptoms?

- ⚪ Constantly (76% - 100% of the day)
- ⚪ Frequently (51% - 75% of the day)
- ⚪ Occasionally (26% - 50% of the day)
- ⚪ Intermittently (0% - 25% of the day)

What describes the nature of your symptoms?

- ⚪ Sharp
- ⚪ Dull ache
- ⚪ Throbbing
- ⚪ Numb
- ⚪ Weakness
- ⚪ Unstable
- ⚪ Shooting
- ⚪ Burning
- ⚪ Electricity
- ⚪ Tingling
- ⚪ Imbalance
- ⚪ Other: _____

Please indicate where you have pain or other symptoms:



Who else have you seen for your symptoms? _____
What treatments have you received, and when? _____
What tests or imaging (ie XRay, MRI, etc.) have you received? _____

What is your goal for physical therapy? _____

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On average, how bad has your pain been…

	No pain										Pain as bad as it can be
In the morning over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the afternoon over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the evening over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
With activity over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10

For the following questions, please circle the number that best corresponds to your views:

To what degree has your injury had a negative effect in your life?	0 No affect at all	1	2	3	4	5	6	7	8	9	10 Severely affects my life
How long do you think your symptoms will continue?	0 A very short time	1	2	3	4	5	6	7	8	9	10 Forever
How much control do you feel you have over your symptoms?	0 Absolutely no control	1	2	3	4	5	6	7	8	9	10 Extreme amount of control
How much do you think your treatment can help your illness? (includes physical therapy, medication, etc.)	0 Not at all	1	2	3	4	5	6	7	8	9	10 Extremely helpful
Thinking of all the symptoms that have arisen as a result of your injury, are you experiencing:	0 No symptoms at all	1	2	3	4	5	6	7	8	9	10 Many different symptoms
How concerned are you about your symptoms?	0 Not at all concerned	1	2	3	4	5	6	7	8	9	10 Extremely concerned
How well do you feel you understand your symptoms?	0 Don't understand at all	1	2	3	4	5	6	7	8	9	10 Understand very clearly
How easily do you feel it would be to injure yourself further?	0 No more easily than normal	1	2	3	4	5	6	7	8	9	10 I could very easily be injured further
How much does your illness affect you emotionally?	0 Not at all affected emotionally	1	2	3	4	5	6	7	8	9	10 Extremely affected emotionally

Optional: Please list in rank-order (most to least important) *up to* three factors that you believe are causing your symptoms:

1. _____
2. _____
3. _____

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