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 or re-schedule an appointment, we require 24- hour notice.

If you do not provide appropriate cancelation 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 two (2) *additional* appointments (a total of three (3) appointments) without 24-hour notice, your future appointments will be cancelled, 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 & 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.

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 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:

• Co-insurance and co-payments are the patient's responsibility. Co-pays are due at every visit.

• Deductibles are 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) Printed Date of Birth

_____

Patient Signature Date

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Sports Rehab Physical Therapy

*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

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

Employer's Address:_____Phone#:_____

*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:_____

Do you have any known allergies to latex, lanolin, or beeswax? ☐ Yes ☐ No (Please inform staff of additional allergies.)

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

Patient Signature: _____ Date:_____

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Patient Name: _____

Have you EVER been diagnosed as having any of the following?

( ) Type 1 Diabetes	( ) Allergies, please list:
( ) Type 2 Diabetes	( )Rheumatic Fever
( ) Asthma	( ) Infectious Disease (Hepatitis, Tuberculosis)
( ) Emphysema/Bronchitis	( ) Kidney Problems
( ) Hearing/Vision Impairment	( ) AIDS/HIV
( ) Seizures/Epilepsy	( ) Obesity
( ) Artificial joints, please list:	( ) Healing problems/open wounds, if yes then list:
( ) Dizziness or Vertigo	( ) Osteoarthritis
( ) High or low blood pressure ( ) Medicated?	( ) Rheumatic arthritis
( ) Mental illness/Depression	( ) Osteoporosis or Osteopenia
( ) Dementia	( ) Anemia
( ) Heart Disease	( ) Developmental or Growth Problems
( ) Angina or Arrhythmia	( ) Systemic Lupus
( ) Pacemaker or Stent	( ) Other Autoimmune Disease
( ) Vascular Disease	( ) Drug or Alcohol Dependency
( ) Multiple Sclerosis	( ) Thyroid Problems (High or Low)
( ) Acute Respiratory Infection	( ) Acute Pulmonary Heart Disease
( ) Stroke	( ) Pneumonia
( ) Cancer If Yes, Date: _____ *Describe:*	( ) Other
List **Medication(s)** or provide list with dosages:	List **Medical/Surgical** History:

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Patient Name: _____
Gender: Male Female
Pronouns: _____
Occupation: _____
Exercise Routine:

_____

Briefly describe your current complaint:

_____

_____

When did this problem begin? _____ Is it getting better____ worse_____ same____

Rate your feelings as to the severity of this problem: 0 1 2 3 4 5 6 7 8 9 10
0 = not a problem 10 = major problem

Do you now have or do you have a history of the following?

- ☐ Bladder infections
- ☐ Urinary frequency, hesitancy, urgency
- ☐ Pelvic pain
- ☐ Low back pain/sciatica
- ☐ Multiple Sclerosis
- ☐ Endometriosis
- ☐ Childhood bladder problems
- ☐ Trouble holding back gas
- ☐ Vaginal dryness
- ☐ Constant dribbling of urine
- ☐ Interstitial Cystitis / Painful Bladder
- ☐ Constipation, IBS, chronic diarrhea
- ☐ Chron's Disease
- ☐ Joint problems
- ☐ Abdominal pain
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS
- ☐ Fecal incontinence
- ☐ Blood in urine
- ☐ Trouble feeling bladder fullness
- ☐ Pelvic Organ Prolapse
  - ☐ o Type:
  - ☐ o Grade:
- ☐ Cancer: Type:

  _____
- ☐ Fibromyalgia
- ☐ Allergies:

  _____
- ☐ Other (please list)

  _____

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OB/GYN History (if appropriate):
Contraceptive History – Currently using a form of birth control? Y / N
Type of contraception used: _____
Are you currently pregnant: Y/N Weeks Gestation: _____ Anticipated delivery date: _____
Vaginal deliveries: _____# C-sections _____ # Episiotomies _____ Forceps Y / N
Complications with delivery / post-partum:
_____
Pelvic Surgical History:
_____
_____
Menstrual History: Age at onset? _____ Date of last menstrual cycle? _____

Painful periods? Y/N
Regular cycles? Y/N
Pain with tampon insertion? Y/N
Pain with ovulation? Y/N
Menopause? Y/N
Hormonal Treatment? Y/N

Any other significant factors in OB/GYN history, please describe:
_____
_____

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Sexual Function:

For pelvic health, sexual function is an important component to be addressed. These questions are helpful in creating a complete treatment plan for you. However, please know you may choose not to disclose any portion of the following information.

Please circle any applicable items:
Are you currently sexually active? Y / N / It's complicated

Orgasm, erectile, clitoral function – check any that apply:

- ☐ Premature ejaculation
- ☐ Painful penetration (vaginal / rectal)
- ☐ Difficulty with erection
- ☐ Painful ejaculation
- ☐ Nocturnal erections
- ☐ Lack of orgasm
- ☐ Pain with orgasm
- ☐ Arousal without completion
- ☐ Low libido / lack of desire

History of sexual abuse? Y/N
Leakage of urine during intercourse? Y/N
Latex allergy? Y/N
Lubricant allergy / sensitivity Y/N
If you use a vaginal or rectal lubricant, what type do you use? _____

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Bladder/Bowel Habits:

Number of times you urinate during the day? ___
Number of times you urinate after going to bed? ___
# of bowel movements per day? ___
Do you take your time to empty your bladder? Y/N
Can you stop the flow of urine? Y/N
Do you strain to pass urine? Y/N
Do you strain to pass feces? Y/N
Do you empty your bladder frequently, before the urge? Y/N
Do you ignore the urge to defecate? Y/N
Does your bladder feel full after urination? Y/N
Do you have a slow, hesitant urine stream? Y/N
Do you have triggers that make you feel you can't wait to urinate or defecate? Y/N
Fluid Intake per day (one glass is 8 oz or one cup):
Number of Caffeinated glasses per day:
Number of Alcoholic glasses per day:

Urine/Fecal Leakage Questions:

Number of urinary leakages daily:
Number of fecal/bowel leakages daily:
Severity of Leakage: None Few drops Wets underwear Wets outerwear
Protection worn: None Minipad Maxipad Full undergarment
Position or Activity with Leakage (check all that apply):

- ☐ Vigorous activity
- ☐ Light activity
- ☐ Changing positions
- ☐ Walking to toilet
- ☐ Laughing
- ☐ Coughing
- ☐ Sneezing
- ☐ Strong urge to go Intercourse or sexual activity
- ☐ No activity changes leakage (constant)

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Pelvic Pain Questions:

"I have pain with…" (check all that apply)

- ☐ Sexual intercourse
- ☐ Urination
- ☐ Defecation
- ☐ At Rest
- ☐ Sitting
- ☐ Standing
- ☐ Tight clothes
- ☐ Exercise
- ☐ Menstruation
- ☐ Orgasm

"Pain is located…." (check all that apply)

- ☐ Deep
- ☐ Surface
- ☐ Vagina
- ☐ Urethra
- ☐ Anus
- ☐ Penile shaft
- ☐ Penile tip
- ☐ Clitoris
- ☐ Labia
- ☐ Scrotum
- ☐ Hip
- ☐ Pubic
- ☐ Rectum
- ☐ Tailbone / Coccyx
- ☐ Tailbone / Sacrum
- ☐ Pubic bone
- ☐ Right side
- ☐ Left side

Approximate pain onset date: _____
Pain is relieved by:_____
Pain is worsened by: _____
Medications, supplements, herbals or topicals:
_____
_____

Any other concerns that you would like the Physical Therapist to know?
_____
_____