

PATIENT INTAKE FORM

Date of Call _____ Intake Initials _____ Verifying Initials _____ Acct# _____
Physical Therapist _____ Appt. date/time _____ Referring MD _____
Patient Name _____ Home # _____ Cell # _____
Address _____ City _____ State/Zip _____
E-mail _____ DOB _____ SS# _____ Sex M ___ F ___
Rx Date _____ Diagnosis _____ Surgery Date _____

Have you had PT/OT this year? _____ If Answered Yes, Where? _____
Have you had a home health aid or Nurse helping you at home? Yes or No _____ How Long? _____ Agency _____

Primary Insurance Info. WC MVA DOA _____ GROUP HEALTH POS PPO HMO Other _____

Name of Insurance Company _____ ID# _____ Group# _____
Phone # _____ Fax # _____ Effective Date _____
Address _____ City _____ State/Zip _____

Policyholder Name _____ SS# _____ DOB _____ Relation _____
Call Date & Time _____ Rep's Name _____ Call Ref.# _____

In Network Benefits	Calendar Yr. From _____ To _____	Out of Network Benefits	
% Covered _____	Copay (or%) _____	% Covered _____	Copay (or%) _____
Deductible Amt. _____	Amount Met _____	Deductible Amt. _____	Amount Met _____
Out of Pocket _____	Amount Met _____	Out of Pocket _____	Amount Met _____
Precert? _____	PCP Referral _____	Precert Required _____	PCP Referral _____
# of Visits/Days Allowed(specify) _____		# of Visits/days allowed(specify) _____	
Dollar Amount Allowed _____		Dollar Amount Allowed _____	
# of Visits/Days/Amount Used _____		# of Visits/Days/Amount Used _____	

Are PT benefits combined with any other benefits? Y or N _____
If yes what? _____

Secondary Insurance Info. WC MVA DOA _____ GROUP HEALTH POS PPO HMO Other _____

Name of Insurance Company _____ ID# _____ Group# _____
Phone # _____ Fax # _____ Effective Date _____
Address _____ City _____ State/Zip _____

Policyholder Name _____ SS# _____ DOB _____ Relation _____
Call Date & Time _____ Rep's Name _____ Call Ref.# _____

In Network Benefits	Calendar Yr. From _____ To _____	Out of Network Benefits	
% Covered _____	Copay (or%) _____	% Covered _____	Copay (or%) _____
Deductible Amt. _____	Amount Met _____	Deductible Amt. _____	Amount Met _____
Out of Pocket _____	Amount Met _____	Out of Pocket _____	Amount Met _____
Precert Required _____	PCP Referral _____	Precert Required _____	PCP Referral _____
# of Visits/Days Allowed(specify) _____		# of Visits/days allowed(specify) _____	
Dollar Amount Allowed _____		Dollar Amount Allowed _____	
# of Visits/Days/Amount Used _____		# of Visits/Days/Amount Used _____	

Are PT benefits combined with any other benefits? Y or N _____
If yes what? _____

Additional Info: _____

EMPLOYER INFORMATION

Name of Employer _____ Phone _____ Extension _____

Address _____

EMERGENCY CONTACT

Name _____ Phone# _____ Relationship _____

ATTORNEY INFORMATION

Name _____ Phone _____ Extension _____

Address _____

Designated Personal Representative:

I _____ hereby authorize _____, _____ as my designated personal
(Patient Name) (Personal Representative) (Relationship to pt.)

representative. The above referenced representative, for purposes of SportsCare Institute, may communicate on my behalf regarding treatment, insurance verification, authorization, referral and insurance payment or denial. This representative designation is effective from initial evaluation date through account reconciliation.

I decline to designate a personal representative _____
(patient signature if declining)

Consent to Treat:

I authorize SportsCare to render physical therapy services as prescribed by the referring physician.

Assignment of Benefits:

I irrevocably assign to SportsCare all my rights and benefits under any insurance contracts for payment for services rendered to me by SportsCare. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by SportsCare to be released to SportsCare. I irrevocably authorize SportsCare to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to SportsCare. I irrevocably authorize SportsCare to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient/Responsible Party Signature Relationship to patient Date Acct#

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT / PATIENT CONSENT

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 this information can and will be used to:

- * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- * Obtain payment from third-party payers.
- * Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, 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 this organization has the right to change its Notice of Privacy Practices from time to time and that I contact this organization at any time to obtain a current copy of the Notice of Private 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 operations. 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.

I understand that I may revoke this consent in writing at any time, except that you have taken action relying on this consent.

Print Patient Name Relationship to Patient Acct#

Patient Signature Date

SPORTSCARE

Medical History Patient Questionnaire

Name: _____ Referring Physician: _____

Family Physician: _____ Date of 1st doctor visit for this injury : _____

Last Day worked due to this injury: _____ / _____ / _____ Date returned to work after this injury: _____ / _____ / _____

Is an attorney involved in this case? YES NO

Have you had Surgery for this Injury? YES NO Number of Surgeries? _____

Type of Surgery? _____ Took place in: Hospital or Surgery Center

Are you currently taking any prescription or non-prescription Medications? YES NO

Anti inflammatories _____ Muscle Relaxers _____ Pain Medication _____

Please list Medications: _____

Are you allergic to any Medications? YES NO List Medications _____

Have you ever had any of the following Medical or Rehabilitative services for this injury?

	YES	NO		YES	NO
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/NCV	_____	_____	General Practitioner	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room Care	_____	_____	X-Rays	_____	_____

Other: _____

Do you have or have had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or frequent headaches	_____	_____
Shortness of breath/chest pain	_____	_____	Vision or Hearing Difficulties	_____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a pacemaker	_____	_____	Dizziness or Fainting	_____	_____
High blood pressure	_____	_____	Bowel or Bladder Problems	_____	_____
Heart attack or surgery	_____	_____	Weakness	_____	_____
Stroke/TIA	_____	_____	Weight loss/Energy Loss	_____	_____
Congestive heart disease	_____	_____	Hernia	_____	_____
Blood clot/ Emboli	_____	_____	Varicose veins	_____	_____
Epilepsy/Seizures	_____	_____	Allergies	_____	_____
Thyroid Disease or Goiter	_____	_____	Any Pins or Metal Implants	_____	_____
Anemia	_____	_____	Joint Replacement Surgery	_____	_____
Infectious Disease	_____	_____	Neck Injury/Surgery	_____	_____
Diabetes	_____	_____	Shoulder Injury/ Surgery	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Arthritis	_____	_____	Back Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Knee Injury/Surgery	_____	_____
Gout	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Sleeping problems/Difficulties	_____	_____	Are you pregnant	_____	_____
Emotional Problems/ Psych. problems	_____	_____	Do you use tobacco?	_____	_____

Please list any other information that would assist us in your care:

Patient/Guardian Signature _____ Date: _____ / _____ / _____