SPORTS AND SPINE PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

How did you hear about Sports & Spine Physical Therapy? (You can choose more than one)
( ) MD ( ) Google ( ) YELP ( ) Friend/Family ( )Insurance co. ( ) Facebook ( ) Phonebook ( ) Instagram
( ) Walk-In ( ) Website ( ) Returning Patient ( ) LinkedIn Other:_____

Have you had surgery for this injury? YES NO **Type of Surgery (Date): _____**
Past Surgeries and/or Other Important Medical History (Dates): _____
_____
_____
Occupation/Work Status: _____
Current Medications and Dosages: _____
_____

Have you had any of the following Medical or Rehabilitative Services for this injury/episode?

	YES	NO		YES	NO
Orthopedist	[ ]	[ ]	MRI	[ ]	[ ]
Neurosurgeon	[ ]	[ ]	CT Scan	[ ]	[ ]
Physical Therapy	[ ]	[ ]	X-Rays	[ ]	[ ]
Occupational Therapy	[ ]	[ ]	Emergency Room	[ ]	[ ]
Chiropractor	[ ]	[ ]	Electromyography	[ ]	[ ]
Podiatrist	[ ]	[ ]	Nerve Conduction Test	[ ]	[ ]

Do you now have or have you ever had ANY of the following?

	YES	NO	PAST		YES	NO	PAST
Diabetes	[ ]	[ ]	[ ]	Hearing Difficulties	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	Vision Difficulties	[ ]	[ ]	[ ]
Severe or Frequent Headaches	[ ]	[ ]	[ ]	Numbness/Tingling	[ ]	[ ]	[ ]
Shortness of Breath	[ ]	[ ]	[ ]	Dizziness/Fainting	[ ]	[ ]	[ ]
Chest Pain	[ ]	[ ]	[ ]	Bowel/Bladder Problems	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	Pins/Metal Implants	[ ]	[ ]	[ ]
Do you have a Pacemaker?	[ ]	[ ]	[ ]	Cancer or Chemotherapy/Radiation	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	Arthritis	[ ]	[ ]	[ ]
Epilepsy/Seizures	[ ]	[ ]	[ ]	Sleeping Problems	[ ]	[ ]	[ ]
Stroke/TIA	[ ]	[ ]	[ ]	Are you pregnant?	[ ]	[ ]	[ ]
Blood Clot/Embolism	[ ]	[ ]	[ ]	Do you use tobacco?	[ ]	[ ]	[ ]
Gout	[ ]	[ ]	[ ]	Other medical concerns: _____			
Emotional/Psychological Problems	[ ]	[ ]	[ ]	_____			

I have read Sports and Spine's Privacy Policy: YES NO **Would you like to receive a copy?** YES NO

Patient/Guardian Signature: _____ Date _____

WHEN DID YOUR PAIN BEGIN?

Approximate date of injury/pain: _____

What happened? _____

_____

PRIMARY COMPLAINT:

Pain Location: _____

Duration of Pain: [ ] Constant [ ] Intermittent

RATE YOUR CURRENT PAIN (0=No Pain → 10=Emergency Room Pain)**:** _____

Nature of Pain: [ ] Sharp [ ] Dull [ ] Aching [ ] Burning
[ ] Radiating [ ] Tingling [ ] Throbbing
[ ] Other: _____

Aggravating Factors: [ ] Sitting [ ] Standing [ ] Walking [ ] Stairs [ ] Sleeping
[ ] Carrying [ ] Lifting [ ] Bending Forward
[ ] Other: _____

Relieving Factor: [ ] Sitting [ ] Standing [ ] Walking [ ] Activity Modifications
[ ] Medication [ ] Heat [ ] Ice
[ ] Other: _____

FUNCTIONAL REPORTING

From the list below, choose the top 2 mobilities/activities that are the most limited (difficult), and rate each limitation from 0% – 100%. (0% = not difficult at all, 100% = unable to perform)

TOP 2 MOST-LIMITED MOBILITIES	**LIMITATION RATING** (0% – 100%)
EXAMPLE: Standing	80% limited
1.	
2.	

Sitting	Rolling over
Standing	Moving—lying to sitting
Climbing stairs	Moving—sitting to standing
Lifting/Carrying	Walking short/long distances
Bending/Stooping	Reaching
Balancing	Grasping

How does your current condition affect or inhibit any activities that you once enjoyed doing?

_____

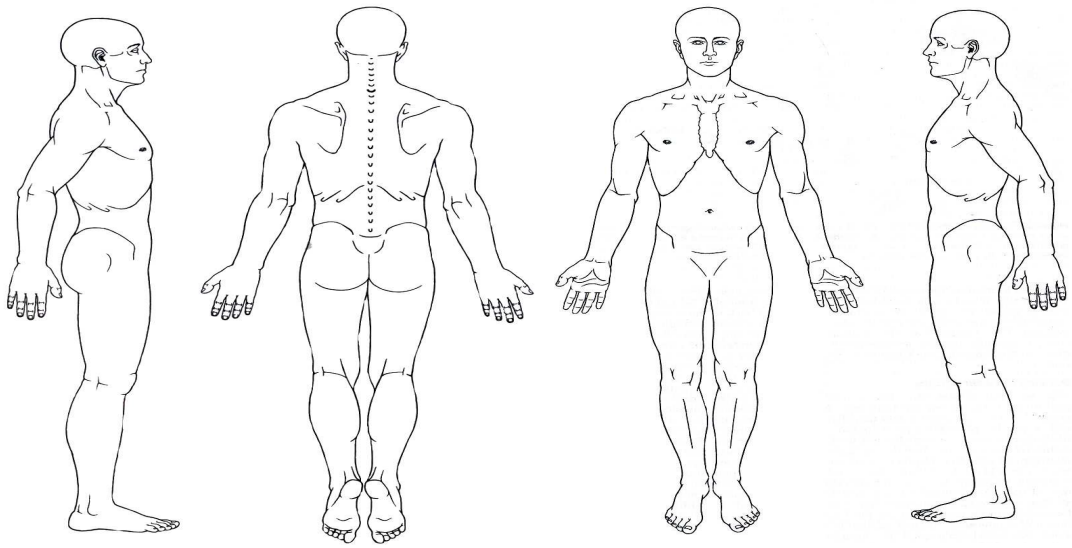
_____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO

What are your physical therapy expectations/goals? _____

_____

MARK ON THE BODY DIAGRAM WHERE YOUR SYMPTOMS ARE:



Sports and Spine Physical Therapy, Inc.

3365 Richmond Rd. Suite 110
Beachwood, OH. 44122

Patient Privacy Protection Policy Notice

As required by the HIPAA Regulations, Sports and Spine Physical Therapy, Inc., protects all medical records and other individually identifiable health information used or disclosed by the clinic, whether electronically, on paper, or orally. Patients of Sports and Spine Physical Therapy, Inc., have significant new rights to understand and control how their health information is used.

Our Patients may view, request a copy of, amend, or receive a list of individuals and organizations that have seen their medical information during the period of the previous six (6) years. Sports and Spine Physical Therapy, Inc., may deny access to a patient's records if it believes that the release of certain information will endanger the life or physical safety of the individual. In all other cases, Sports and Spine Physical Therapy, Inc., has sixty (60) days from the date of request to make the information available. Sports and Spine Physical Therapy, Inc., may provide a summary of the data instead of the actual data itself and may charge a fee that is usual and customary for providing this information. Such amounts are set by law and revised on an annual basis. Sports and Spine Physical Therapy, Inc., is not required to include the following material: (i) information submitted by a patient that is generated by another provider, (ii) information that is known to be inaccurate, or (iii) information that is not part of the patient's record set.

Patient education on privacy protections. Sports and Spine Physical Therapy, Inc., is required to develop a Notice of Privacy Practices (the "Notice"). The Notice must explain, in plain English, how the clinic may use and disclose a patient's personally identifiable health information. The clinic is required to maintain the Notice in a visible location and must provide each patient with a physical copy of the Notice.

Ensuring patient access to their medical records. Patients will be able to view and obtain copies of their records. They may also request amendments to their records to reflect inaccuracies in the medical record. In addition, a history of non-routine disclosures must be made accessible to patients. Applicable copy charges must be reasonable and customary and must comply with state law.

Receiving patient consent before information is released. Sports and Spine Physical Therapy, Inc., is required to obtain patient consent before sharing their information for treatment, payment, and health care operations. In addition, separate patient authorization must be obtained for non-routine disclosures and most non-health care purposes. Patients will have the right to request restrictions on the uses and disclosures of their information.

Providing recourse if privacy protections are violated. Patients will have the right to file a formal complaint with Sports and Spine Physical Therapy, Inc., or with the Department of Health and Human Services ("HHS"), concerning violations of the provisions of the Regulations or any related policies and procedures of the clinic.

SIGNATURE: DATE:

Sports and Spine Physical Therapy, Inc.
Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for ***Sports and Spine Physical Therapy*** to furnish medical care and treatment to _____
considered necessary and proper in diagnosing or treating his/her physical condition.
Patient/Guardian/Responsible party_____ Date_____

Benefit Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Sports and Spine Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary.
Patient/Guardian/Responsible party_____ Date_____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***Sports and Spine Physical Therapy.***

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize ***Sports and Spine Physical Therapy,*** if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. This does not however, mean that Sports and Spine Physical Therapy cannot collect a returned check fee by other methods. Our returned check fee is $25.00 per occurrence.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including all court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Date

SPORTS & SPINE PHYSICAL THERAPY
CANCELLATION & NO-SHOW POLICY

Sports & Spine Physical Therapy, Inc. is committed to providing each patient with the highest quality of care while attempting to accommodate your schedule. We reserve each treatment time slot with a specific therapist in order to consistently provide both excellence of treatment and continuity. An appointment time reserved for you precludes any other patient who needs treatment from being seen at that time. No-Shows and Cancellations negatively impact all of our patients as well as the individual therapist and our facility.

We truly appreciate the opportunity to assist in your care. Therefore, in order to serve all of our patients with top quality of service, we believe the following policy is necessary for all patients and should be taken seriously:

- **Should you fail to call before the 24 hour time period, you will incur a $15.00 late cancellation fee.**

- **There is a $75.00 No Show fee when Sports and Spine Physical Therapy receives no call before the scheduled appointment time.**
  ANY FEE ASSESSED MUST BE PAID BY NEXT SCHEDULED APPOINTMENT.

- 24 hours notice is considered to be calling the office anytime before close of business on the day before your appointment. In the event that the office is not open, leaving a message is **NOT** considered 24 hour notice.

- In the event that we do not receive notification, you may have your future scheduled visits canceled until you reschedule them.

- All cancellations and no-shows are subject to be documented in your medical record and/or reported to your Case Manager, Employer, Third Party Administrator and Physician.

Thank you for your cooperation and consideration.

The Staff at Sports & Spine Physical Therapy, Inc.

PLEASE SIGN AND DATE

Patient Agreement: _____ Date: _____