Date:_____

Legal Last Name_____ First Name_____ Middle Initial_____ Nickname_____

Social Security #_____ Date of Birth _____ /_____ /_____ Sex: Male [ ] Female [ ]

Address_____ Apt_____

City_____ State_____Zip_____

Marital Status: Married [ ] Single [ ] Legally Separated [ ] Divorced [ ] Widowed [ ]

Race_____ Language_____ Ethnicity_____

Phone # (preferred) _____ Alternate phone # (if needed) _____ Leave a message: Yes [ ] No [ ]

Email Address: _____

Referring Physician _____ Primary Care Provider _____

In case of an emergency who should we contact?

Name_____Relationship_____ Phone_____

Name_____Relationship_____ Phone_____

In the event that I (or in the case of a minor, the personal representative of said minor) cannot be reached directly to discuss Patient Health Information, Sports & Spine Physical Therapy is authorized to leave a message by voice mail, answering machine, with any individual listed above as Emergency Contact(s), or with any individual who answers any of the telephone numbers listed on this form.

Are you the primary Subscriber on your Insurance plan? [ ] YES [ ] NO

If No, please list Subscriber Name _____ and Date of Birth _____ /_____ /_____

Patient Signature:_____ **Date:**_____

Parent of Guardian Signature:_____Date:_____

Initials of person completing the form, if other than the patient_____

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** _____

CONTINUE ON BACK

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?

_____

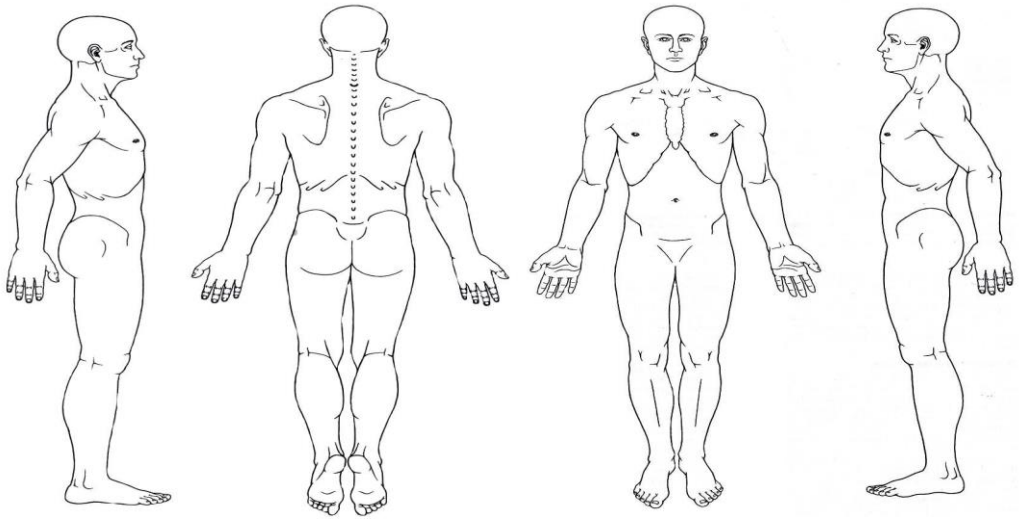
_____

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

What are your physical therapy expectations/goals? _____

_____

MARK ON BODY DIAGRAM WHERE YOUR SYMPTOMS ARE:



Patient Name: _____

Patient Date of Birth: _____

1.03 HIPAA Patient Acknowledgment

I hereby permit Sports & Spine Physical Therapy, Inc. to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of Sports & Spine Physical Therapy, Inc. (SSPT) privacy policy. I may request a paper copy of the SSPT Notice of Privacy Practices at any time. I permit SSPT to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit SSPT to send me any information via electronic messaging (including email or text) or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for SSPT to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission for the following individuals to receive my medical information:

☐ Patient only

(name)	(relationship)	(phone number)	(leave message Yes/No)
(name)	(relationship)	(phone number)	(leave message Yes/No)
(name)	(relationship)	(phone number)	(leave message Yes/No)
(name)	(relationship)	(phone number)	(leave message Yes/No)
(name)	(relationship)	(phone number)	(leave message Yes/No)

PAYMENT AUTHORIZATION

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM SSPT DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to SSPT for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, a credit bureau report may be obtained. I understand in some cases it may be necessary to obtain insurance / employer verification. SSPT cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). SSPT fees are not established by insurance companies. I am responsible for my account. It is solely my responsibility to know who my insurance is in network with.

No Show Policy

I hereby understand that SSPT has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I hereby provide my consent for SSPT, to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to- system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the

Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying Human Resources or the IT Department.

Electronic Communications

I authorize SSPT to contact and communicate with me by various electronic communication methods, including e-mail, text messages, direct EMR messaging. I understand that I may receive electronic communications from or on behalf of SSPT regarding my treatment (e.g., test results, prescription refill reminders, appointment reminders, etc.) 1.03 HIPAA Patient Acknowledgment Revised 12/09/2020 and the payment for my treatment (account statements and invoices, electronic payment of outstanding balances, etc.). I further understand that my authorization will apply to all future communication unless I subsequently elect not to receive electronic communications or request a change, which I may do at any time without penalty or consequence by notifying [insert] in writing. Sports & Spine Physical Therapy does not charge for any electronic communications; however, standard messaging or service rates may apply as provided by your communications carrier.

Signed _____ Date _____

Sports and Spine Physical Therapy, Inc.

DATE: _____ Patient Name: _____

Sports & Spine Physical Therapy's (SSPT) Front Office staff are working as a courtesy to you to determine eligibility & coverage of your insurance(s) for Physical Therapy (PT) services. On your behalf, we contacted your insurance and were provided with the following information:

Date of Contact: _____ Phone #: _____

**** This coverage determination does NOT Guarantee payment by your plan.****

According to your insurer:
You ARE ( ) ARE NOT ( ) eligible for PT benefits at this time.

Patient Responsibility:

- ☐ You have a $_____ total **DEDUCTIBLE** and you have $_____ additional dollars due. The cost of each visit will go towards your deductible **and the balance will be billed out to you**. Estimated cost per visit: $_____.

- ☐ You have a $_____ **CO-PAY due at each visit**. (*Please be informed that SSPT will collect your copays at each visit.*)

- ☐ You have a _____**CO-INSURANCE** due for each visit and **will be billed out to you once you have met your deductible**, if applicable. Estimated amount: $_____.

You have a PT Benefit limit of up to _____# of visits per year.

PRIOR AUTHORIZATION required for additional visits? ( ) YES ( ) NO
If **yes**, we will submit a request to your insurance after your evaluation. This will tell us exactly how many visits your insurance company approves for you.

Other Plan Limits and/or notes:
_____
_____
_____

Please be advised that bills for services rendered beginning February 1, 2025 will no longer be issued by NOMS Healthcare. Going forward, all billing statements will be sent by COSI (Cleveland Orthopedic and Spine Institute).

( ) I WANT TO RECEIVE A COPY **( )** I DO NOT WANT A COPY

Signature: _____ **Date:** _____

SPORTS & SPINE PHYSICAL THERAPY

CANCELLATION & NO-SHOW POLICY

We at Sports & Spine Physical Therapy, Inc. are 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 <u>before</u> the 24 hour time period, you will incur a $15.00 same day cancellation fee.**

- **There is a $50.00 No Show fee when Sports and Spine Physical Therapy receives <u>no call</u> before the Scheduled appointment time.**

- **ANY FEE ASSESSED MUST BE PAID BY THE 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 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.

<u>PLEASE SIGN AND DATE</u>

Patient Agreement: _____ Date: _____

CLEVELAND ORTHOPEDIC & SPINE INSTITUTE