Total Sports Therapy PATIENT REGISTRATION FORM

Patient Information

Please print clearly and sign below

Date:____________________________

Name (Last) ___________________________________ **(First)** ________________________ (M.I.) ____ (Suffix) _____

Birth Date____________ **Sex**: (M) (F)

Address _______________________________________ City _________________ State ________ Zip____________

Social Security#___________________________________

If the patient is a minor, please put social security number of the responsible party.

*******DIVORCE SITUATIONS:*******

In cases of divorce, it is *our policy* that any amount left owed after insurance has been paid will be the responsibility of the *parent who brings the child for their appointments*. This is between you and your ex-spouse. We do not bill to anyone other than the parent who initiated the appointment and brings them for their appointments. No exceptions.

Is This Patient A Minor? YES NO

Drivers Lic #_______________________________________ **(Only required if SS# not supplied)**

Home Phone (____) ____________ Work Phone (____) ________________ Cell Phone (____) _____________

How do you prefer to receive your statements: ❑ E-mail ❑ Mail E-mail________________________________

Employer: ____ Occupation: ___________________________________

Address ____ Phone (_____) _________________

Referring Physician (if applicable) _______________________________________ Telephone _____________________

Who may we thank for your referral other than your Doctor? ____

Marital Status: Single / Married / Divorced / Widowed / Separated / Domestic Partner / Minor Child

Name of Spouse or Parent (if patient is a minor): ____________________________ Birth date: ____________

Employed by: _____________________ Occupation: _____________________ Bus. Phone: ________________

Address: ____ City: __________________ State: ________ Zip: _______

Emergency Contact ___________________________ Relationship _________________ Phone (____) ___________

Name and address of closest relative (other than spouse/parent) in case of emergency:

Name: _____________________ Address: _____________________________ City: ______________ State: _______

Zip: _______ Phone: ________________________

INSURANCE INFORMATION (Please Complete)

Primary Insurance___________________________________ Policy # ____

Cust. Service Phone #_____________________ Insured Name ___________________________________ D.O.B.__________

Patient(non-minors)/Guardian/Responsible Party Signature:_______________________________**Date:**__________

Total Sports Therapy

MEDICAL HISTORY

Patient Name____ Age________

Type of Injury / Condition ____

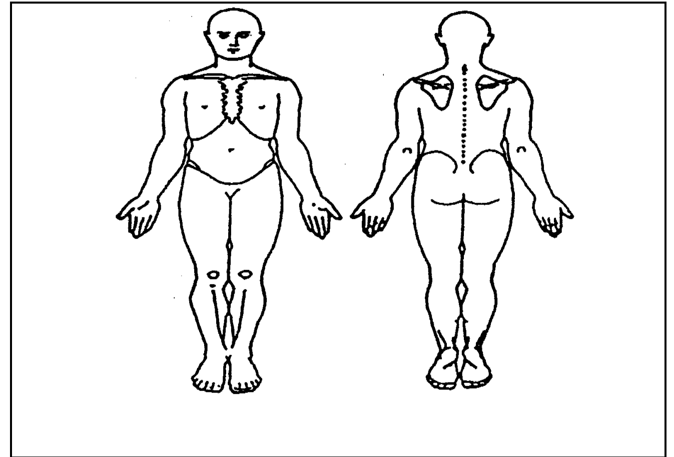
Onset / Injury Date______________________________

Type of Surgery & Date ______________________________

Next Doctor's Appointment? ______________________________

Describe previous treatment for this condition______________________________

____



Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Please mark the area(s) of concern

Have you recently noted:

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain At Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps In Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision Or Hearing
- ☐ Insomnia

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

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________________

Explain & give approximate dates for any items indicated above______________________________

____

Are you currently taking medications? Yes / No Name or Type of Medication ______________________________

____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ______________________________

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?______________________________

____

What are your physical or fitness goals: ______________________________

Is there anything else you would like to include or ask your physical therapist? ______________________________

____

Patient or Personal Representative Signature **Date**

____

Financial Policy: As a courtesy, we will bill the primary insurance company for our patients, if we are provided the necessary information. This also includes Personal Injury Protection claims (PIP) and the state (L&I or private Worker's Compensation, Medicare and Medicaid). Co-payments are due at the time of each visit. It is important to communicate any financial problems as soon as possible. All patient balances must be paid within three (3) months of the last date of service, unless an approved payment plan has been created. Please contact the business office directly to discuss a mutually agreeable payment plan so you will not jeopardize your credit. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. In the event of non-payment and/or no payment plan, formal collections procedures may become necessary and you will be responsible for an additional 30% due to collection agency costs.

Your insurance is a contract between you, your employer (if necessary), and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what their insurance company allows for therapy, obtain prior approval (if necessary) and follow up with their insurance company on all unpaid visits.

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed. A statement will be mailed to you after the denial has been received from your insurance company. This notice will hold for duration of your treatment for this injury. These denials may include, but are not limited to:

- Medical Necessity
- Required Documentation Missing
- Investigational Coding
- Processing Dispute
- Exceeds Plan Limits
- Preauthorization not obtained by patient or by Total Sports Therapy

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Patient Consent and Release: I understand that I am financially responsible for all charges for service rendered regardless of litigation, insurance reimbursement, or pending L&I claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I request and consent to the performance of evaluation, treatment and procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time.
I authorize Total Sports Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Total Sports Therapy for any benefits available under my insurance plans.

NO-SHOW POLICY: We require at least same day notice in the event of a cancellation. The charge for a no-show without notice prior to scheduled visit is $25. This charge will not be covered by insurance, but will have to be paid by you personally. Patients that are over 15 minutes late for their appointment will be considered a NO-SHOW, regardless if a phone call stating they are going to be late was made. Effort will be made to still see the patient, but there is no guarantee the therapist will have the time. Rescheduled no-show appointments must be attended to avoid the no-show fee.

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Patient (non-minors)/Guardian/Responsible Party **Date**

Co-Pay	Co-Insurance
Estimated Co-Pay $______________/visit **We will collect your co-pay on the last visit of each week.**	**Estimated** Co-Insurance $______________/visit Deductible $______________/year **We will collect you estimated co-insurance or deductible at the last visit of each week.**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with out Notice of Privacy Practices (NPP). This **Notice** describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to request corrections to you information;
2. The right to request that your information be restricted;
3. The right to request confidential communications;
4. The right to a report or disclosures of your information; and
5. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This **Notice** contains information about how we will insure that your information remains private. If you have any questions about this **Notice**, the name and phone number of our contact person is listed on this page.

Drew Giardina, Director of Outpatient Physical Therapy
(480) 272-7140

Acknowledgement of Notice of Privacy Practices

" I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**.I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICE** should it be amended, modified, or changed in any way."

Patient or Representative Name (please print)

Patient or Representative Signature Date

☐ Patient Refused to Sign ☐ Patient Was Unable to Sign Because

CONTACT INFORMATION AUTHORIZATION

When you provide your contact information, you authorize Total Sports Therapy and it's agents to use the mailing address, email address and telephone numbers (landline, wireless, residential or business) you provide, for the purpose of communicating with you regarding appointment information, account information or other clinical or non-clinical information pertinent to services rendered by Total Sports Therapy. You also agree to accept live calls, automated calls, text or other messages from Total Sports Therapy and it's agents as well as grant them to leave recorded messages.

I am the patient, and/or an authorized representative of the patient, and hereby agree to the terms listed above.

____ ________________
Patient Last Name, Patient First Name Date Signed

___________________________ ___________________________
Mobile Phone Number Email Address

___________________________ ___________________________
Home Phone Number Alternate Phone Number