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 both legal parents. This is between you and your ex-spouse. We do not bill to anyone other than the legal parent who signed the financial paperwork. Any balance not paid that goes to collections will be done so in the names of both legal parents. 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? _____

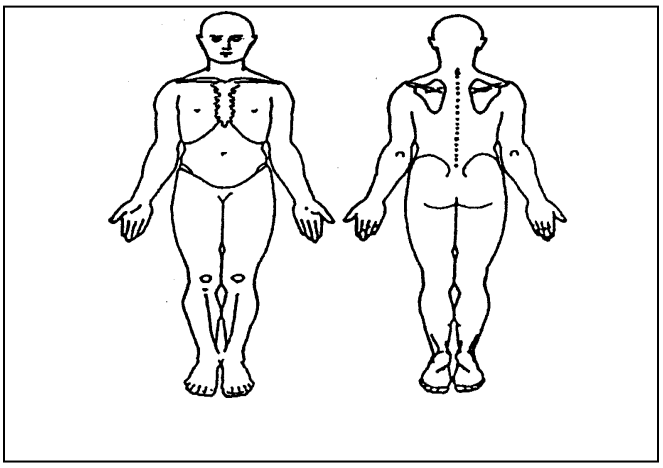
Describe previous treatment for this condition _____

_____

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



Please mark the area(s) of concern

Have you had any imaging performed:

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

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.

_____

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

Co-Pay	Co-Insurance
Estimated Co-Pay $_____/visit	**Estimated** Co-Insurance $_____/visit
	Deductible $_____/year
We will collect your co-pay on the last visit of each week.	**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 our 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 your 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 ensure 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

INSURANCE AND PATIENT RESPONSIBILITY

At Total Sports Therapy, we guide you through your first visit and introduce you to the physical rehabilitation process. We also work with you to make the billing process go as smoothly as possible and ensure your questions are answered along the way. As a courtesy, TST will review your plan benefits we receive from your insurance company and work with you on payment options, if needed.

Additionally, we bill your insurance company on your behalf and work to collect the amount you owe, including:

- Deductible, the amount you must pay before your insurance company begins to pay for services
- Copayment, the fixed amount due at the time of your appointment
- Co-insurance, a form of cost sharing that requires you to pay a percentage of your medical services after your deductible has been met
- Cost for any service not covered by your insurance plan

We highly recommend that you contact your insurance company before your first appointment to confirm therapy services.

Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. We are only relaying information your insurance has quoted us and we are informed by your insurance that the information we receive is "not a guarantee of coverage or benefits". The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.

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