Total Sports Therapy MINOR PATIENT REGISTRATION FORM

Please print clearly and sign below

Date:_____

Patient Name (Last) _____**(First)** _____ (M.I.) ____

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

Social Security#_____**offinancially responsible party.**

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

Address _____City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ How do you prefer to receive your statements: ❑ E-mail ❑ Fax ❑ Mail

E-mail_____ Fax(____) _____

Guarantor:_____ Occupation: _____

Address _____ Phone (_____) _____

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

Referring Physician (if applicable) _____ Telephone _____

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

Name of Parent : Mother _____ phone:_____

Father _____ phone:_____

Name and address of closest relative or friend 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._____

All professional services rendered are the ultimate responsibility of the patient.

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? _____

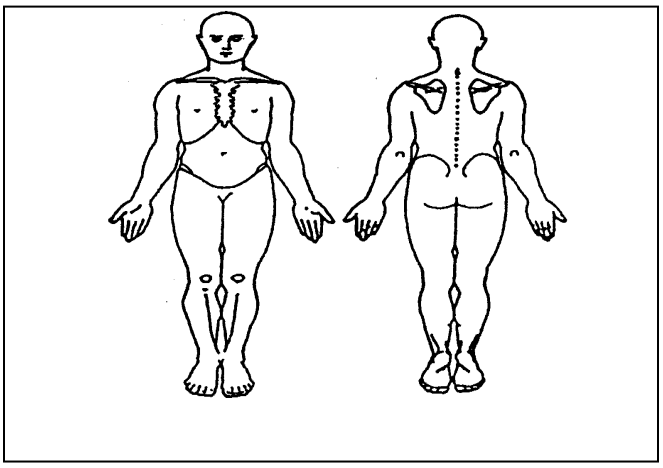
Describe previous treatment for this condition _____

_____

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.

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

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
- Processing Dispute
- Required Documentation Missing
- Exceeds Plan Limits
- Investigational Coding
- 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.

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

_____

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.**

***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.**

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

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patients and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize, and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plans, to issue payment check(s) directly to **Giardina Sportsmedicine Consultants, Inc., Dba:Total Sports Therapy** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information and Consent to Treat

I hereby authorize **Giardina Sportsmedicine Consultants, Inc., Dba: Total Sports Therapy** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Giardina Sportsmedicine Consultants, Inc., Dba: Total Sports Therapy** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. 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.

_____

Print Name of Patient/Responsible Party

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Parent/Guardian Signature **Relationship**

Cancellation Policy

Total Sports Therapy requires cancellation of an appointment before the day of your treatment. There is a $50 charge same day cancellation without proper notice. This charge will not be covered by your insurance and will be collected at your next visit. We understand that extenuating circumstances may occur, which is why we allow TWO (2) same day cancellation free of charge. After TWO (2) same day cancellation, a $50 fee will be assessed. *****CANCELLATIONS OF APPOINTMENTS IS REQUIRED BY PHONE. EMAIL CANCELLATIONS (including replying to appt reminders) IS NOT ACCEPTED AS A CANCELLATION***

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 a scheduled visit is $50. 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.

After THREE consecutive same day cancellations or no-shows (or combination of), you may be discharged from physical therapy. Repeated cancellations and/or no shows will hinder your care. Maintaining regular treatment sessions is essential for positive outcomes.

Lateness Policy

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however; simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 15 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive more than 10 minutes early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. You, the patient – for not receiving the treatment you need.
2. Your therapist – as now he or she has a gap in the schedule.
3. Another patient –who could have had your appointment time.

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

I consent to the above, as indicated by my signature below:

_____	_____	_____
Print Name	Signature	Date

TOTAL SPORTS THERAPY

Personalized Orthopedic & Sports Physical Therapy

CREDIT CARD AUTHORIZATION FORM

I authorize Total Sports Therapy to charge my credit card for an outstanding invoice after 20 days of receiving the invoice. All self-pay services will be charged at the time of service.

All No Show and Cancellation fees will be charged to credit card when occurred.

Print Name: _____

Signature: _____

Date: _____

Credit Card Information

CC Type:	
Cardholder Name:	
CC Number:	
Expiration Date:	
CVC:	
Billing Address:	

This credit card information will be stored on two software databases. Webpt will hold this signed paper copy and Tebra will store the credit card number. Tebra encrypts the card information. None of this information is stored by Total Sports Therapy.

Total Sports Therapy is held harmless in the event of a security breach on either software program.