SPORTS & ORTHOPEDIC
PHYSICAL THERAPY

NEW PATIENT INFORMATION
(Please Print)

PATIENT NAME: _____

ADDRESS: _____ CITY_____ ST: ____ ZIP: _____

EMAIL ADDRESS: _____

BIRTHDATE: _____ AGE: _____ M/F: _____

HOME PHONE: _____ WORK: _____ CELL: _____

SPOUSE OR PARENT NAME: _____

BIRTHDATE: _____ CONTACT PHONE: _____

NAME OF NEAREST RELATIVE: _____ PHONE: _____

WORKERS COMP OR AUTO INSURANCE PATIENTS

INSURANCE COMPANY: _____PHONE: _____

ADDRESS: _____ CITY: _____ST:_____ ZIP: _____

ADJUSTER: _____ CLAIM #: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

AUTHORIZATION: I HEREBY AUTHORIZE SPORTS & ORTHOPEDIC PHYSICAL THERAPY TO FURNISH INFORMATION TO INSURANCE CARRIERS AND HEREBY ASSIGN SPORTS & ORTHOPEDIC PHYSICAL THERAPY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE, AND IF MY INSURANCE COMPANY SHOULD FAIL TO PERFORM, I AM STILL LIABLE FOR THE CHARGES DUE TO SPORTS &ORTHOPEDIC FOR SERVICES RENDERED.

SIGNATURE: _____ DATE: _____

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Medical History / Subjective Information

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Have you ever been diagnosed with any of the following? *Please circle Yes or No*

Tuberculosis:	Yes	No	Cancer:	Yes	No	Arthritis:	Yes	No
Diabetes:	Yes	No	Hepatitis:	Yes	No	Stroke:	Yes	No
Heart Condition:	Yes	No	Epilepsy:	Yes	No	Respiratory:	Yes	No

Other conditions/problems/complications you feel your P.T. should know:_____

Who referred you to physical therapy?_____

Tell Us About Your Condition:

When did you first notice the pain or have functional problems due to the condition/injury:_____

_____ Recent Flare-up? YES NO If yes, when_____

What activities are limited by this condition? (e.g. lift, reach, bend)_____

How did your injury/symptoms occur?_____

What do you expect to accomplish with physical therapy?_____

Are your symptoms: Constant Intermittent Getting Better Getting Worse Staying the Same

What makes your symptoms better?_____

Pain Scale: 0-10 pain scale (0=No Pain and 10=Extreme Pain) Worst:_____ Best:_____ Now:_____

For this injury, has your medical care included: (circle all those that apply)

Surgery: When?_____ What type of surgery?_____

Injections: When?_____ Did it help? YES NO

Physical Therapy: YES NO Chiropractor: YES NO Massage: YES NO

Medications:_____

X-ray, MRI, CT scan:_____

Work Information:

Who is your employer?_____ What is your job title?_____

Are you currently working? YES NO If yes, number of hours per week:_____ Full Duty or Modified Duty

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PATIENT INFORMATION AND TREATMENT CONSENT FORM

I have read and fully understand Sports & Orthopedic Physical Therapy's Notice of Information Practices. I understand that Sports & Orthopedic Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sports & Orthopedic Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. A letter describing agreement/disagreement with my request for restrictions will be sent to me within 15 days of receipt of my request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as notes in Sports & Orthopedic Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I understand that as a patient I am under the care and control of my physician(s) and that my therapist is not liable for any act of omission when providing treatment in accordance with my physician's instructions. I acknowledge that no guarantee or assurance has been, nor can be made by my physical therapist as to the results of the prescribed treatment.

By signing this Informed Consent to Treatment, I consent to have Sports & Orthopedic Physical Therapy Clinic provide the treatment and care prescribed by my physician and I accept the responsibility to inform the therapist, director patient care, or the office manager if a problem exists which needs attention. I also understand that this consent may be revoked in writing by me at any time.

_____ _____

Date Signature

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Financial Policy

Payment in full is required at the time of service for all services provided unless you fall into one of the categories listed below. All patient co-payments are due and payable at the time of service. If you are unable to make your co-payment at the time of service, please make sure payment arrangements are made prior to departure,

Insurance Billing: As a courtesy, this facility will bill your insurance on a weekly basis if you belong to any carriers we are currently contracted with. It is your responsibility to make sure that we have current copies of your card(s); any completed claim forms necessary and correct billing addresses. Please note that you, as the patient, are responsible for knowing the scope of your health coverage benefits. We will also do most secondary billing, providing we have complete secondary billing information.

Worker's Compensation: This facility will bill for worker's compensation injuries. The patient is also responsible to provide this facility with any/all necessary billing information at the first visit. All visits must be prior authorized in advance of any treatment. Please be aware that we are required to notify both your physician and workers compensation carrier of your failure to show for a scheduled appointment. Once the worker's compensation carrier has released a patient from its financial responsibility or benefits have been denied, the patient is then responsible for payment in full of services rendered.

Personal Injury or MVA: As a courtesy, this facility will bill the patient's Auto Insurance, if all the necessary information is provided at the first visit. To avoid any possible litigation, this facility WILL NOT bill any third party liability for patients. Liens for these types of injuries can be provided-as long as an attorney has been obtained by the patient. Patient will be responsible for payment in full should the claim be denied by insurance or payment is delayed more than 60 days.

Monthly Statements: Statements are generated at this facility on a monthly basis via "Cycle" billing. They are a request for payment of what is currently at "Patient Due" responsibility. All patient balances are due and payable upon receipt of the statement, unless special payment arrangements have been made with the billing department in advance.

Signature of Patient and/or Responsible Party Date

_____

6335 N. Fresno St., Suite 108, Fresno, CA 93710 ، (559) 432-0524 ، Fax (559) 449-8646

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NO SHOW/CANCELLATION POLICY

Please be courteous and call Sports and Orthopedic Physical Therapy promptly if you are unable to attend your scheduled appointment.

If it is necessary to cancel your scheduled appointment we require that you give at least 24 hours' notice. Availability of appointments are in high demand and your early cancellation will give another patient the ability to make an appointment.

Patients who cancel without 24 hours' notice or are a no show will be charged a $25.00 fee.

Sign_____ Date _____