ARTHRITIS & SPORTS

Orthopaedics • Physical Therapy • Wellness

Patient Registration

First Name: _____ DOB: _____

Last Name: _____ SSN: _____

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Sex: _____

Injury Area: _____ Date of Injury: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Want to receive appointment reminder texts instead of phone calls? Text **asopt** *to 622622.*

Insurance

Primary Insurance: _____ Policy Eff Date: _____

Subscriber: _____ Subscriber DOB: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Eff Date: _____

Subscriber: _____ Subscriber DOB: _____

Policy #: _____ Group #: _____

If Work Comp case, please fill out the following:

Claim #: _____ Adjustor's Name: _____

Contact Number: _____ Fax Number: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

Are you receiving, or have you recently received, home health services or other therapy services **(please circle one)? Y N**

If yes to either, how many visits did you receive in the past year: home health _____ other therapy _____

CONSENT FOR TREATMENT: I consent to rehabilitation and related services at Arthritis & Sports PT. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. Initial: _____

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initial: _____

LIABILITY: I know and agree that Arthritis & Sports PT is not responsible for loss or damage to personal valuables. Initial: _____

FEE FOR SUPPLIES: Insurance will not cover certain supplies that are suggested by the therapists, including the electrodes used for muscle stimulation/neuromuscular re-education. I understand, as a patient, that I am financially responsible for the cost of these items. Initial: _____

I certify that all the information provided herein is true and correct.

Patient/Guardian Signature: _____ Date: _____

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Medical History

Patient: _____ **Today's Date:** _____

General Information

1. Cause of injury/onset? _____
2. Which physician/doctor referred you today? _____
3. Have you had Physical Therapy for this condition **(please circle one)? Y N**

   If yes, what was done? _____
4. Have you recently been hospitalized (**please circle one)? Y N**

   If yes, when and what for? _____

Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer/ Invalid	***Please Mark One Box For Each Item***	No	Yes Under a Year	Yes Over a Year	No Answer/ Invalid
Allergies (latex)	☐	☐	☐	☐	Heart condition	☐	☐	☐	☐
Allergies (other)	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Bladder/bowel problems	☐	☐	☐	☐	Kidney condition	☐	☐	☐	☐
Blood clot/DVT	☐	☐	☐	☐	Metal implants	☐	☐	☐	☐
Breathing difficulty/asthma	☐	☐	☐	☐	Night sweats/night pain	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Chronic pain/fibro	☐	☐	☐	☐	Pacemaker	☐	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	☐	Peripheral neuropathy	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Pregnancy	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Psychological conditions	☐	☐	☐	☐
Dizziness/faintness	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Fever/nausea	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Fractures	☐	☐	☐	☐	Smoking (including smokeless tobacco)	☐	☐	☐	☐
Groin numbness	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Head injury	☐	☐	☐	☐	Unexplained weight loss	☐	☐	☐	☐

Any other medical problems? _____

_____

Any other surgeries? _____

"NOTICE OF PRIVACY PRACTICES" - ACKNOWLEDGEMENT OF RECEIPT

By signing this page, I acknowledge having received the HIPAA notice that describes how medical information about me may be used and disclosed.

I, _____, hereby allow Arthritis and Sports Orthopaedics to release my private healthcare information to

(Spouse, Children, Other): _____, _____, _____.

Patient Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

As the patient whose name appears below, I hereby authorize Arthritis & Sports Orthopaedics, P.C. to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Arthritis & Sports Orthopaedics, P.C. for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Arthritis & Sports Orthopaedics, P.C. all co-insurance, co-pays, and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Arthritis & Sports Orthopaedics, P.C. Further, I will be responsible for payment of charges not covered by my insurance plan.

Payment is expected at the time services are rendered. All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of insurance carrier. Arthritis & Sports Orthopaedics, P.C. will bill charges to the patient's insurance carrier(s) and any remaining amount will be billed to the patient. Any balance due, for whatever reason, e.g. co-payments, failure to have proper referral, denial of worker's compensation benefits, patient failure to provide accurate insurance information on a timely basis, is the patient's responsibility. Amounts which are the patient's responsibility are to be paid within 30 days, and Arthritis & Sports Orthopaedics, P.C. reserves the right to increase any overdue patient balance by 10% as a late fee immediately and every 30 days thereafter. Should the patient's account be turned over to a collections agency and/or an attorney for payment due, the patient and/or guarantor shall be charged and be held responsible for an additional 30% of the principal amount in collection fees, and all attorney fees; the principal amount includes any outstanding patient balance. The patient and the guarantor agree to be responsible for and to pay interest of 18% on any unpaid balance due to Arthritis & Sports Orthopaedics, P.C. The staff of Arthritis & Sports Orthopaedics, P.C. will gladly assist you with any aspect of this policy.

Cancellation and Late Arrival Policy (effective September 1, 2018)

Please be advised that if you arrive late for your appointment it may be delayed or rescheduled. If you are unable to keep your appointment, we require 24-hour notice of cancellation in order to avoid a **$100** fee.

THE PATIENT AND/OR GUARANTOR SIGNATURE(S) BELOW INDICATE(S) ACCEPTANCE OF RESPONSIBILITY FOR PAYMENT OF ALL CHARGES AND FEES ABOVE.

_____

PATIENT SIGNATURE

PAYMENT GUARANTEED

IF PATIENT IS A MINOR, PLEASE SIGN AND FILL OUT GUARANTOR INFORMATION

_____

GUARANTOR SIGNATURE