



OFFICE USE ONLY:
DATE OF REFERRAL: _____
DIAGNOSIS: _____
EVAL DATE: _____

PATIENT REGISTRATION

NAME: _____ SSN: _____

ADDRESS: _____ DRIVERS LICENSE #: _____

CITY: _____ In an emergency, who should we contact? _____

STATE: _____ ZIP: _____ NAME: _____

EMAIL: _____ PHONE: _____ RELATION: SPOUSE
 PARENT/ GUARDIAN
 FRIEND

HOME PHONE: _____

WORK PHONE: _____ EMPLOYER: _____

CELL PHONE: _____ EMPLOYER PHONE#: _____

BIRTH DATE: _____ SEX: MALE FEMALE
(circle one) WORK ADDRESS: _____
REFERRING PHYSICIAN: _____

Please describe your injury/condition (circle one):

WORK-RELATED AUTO ACCIDENT PERSONAL INJURY LIEN NONE OF THESE

DATE OF INJURY: _____ or No injury date EMPLOYER AT DATE OF INJURY: _____

Are you represented by an attorney for this injury? YES NO EMPLOYER ADDRESS _____

If YES, please list the name of your attorney: _____ EMPLOYER PHONE _____

Please give us all pertinent information regarding your insurance coverage for this case, If you have more than one carrier, please give us information for both carriers. Please show all numbers on your card(s). We will need copies of all applicable insurance cards, as well. Thank you for your assistance.

PRIMARY INSURANCE: _____ or DO NOT BILL INSURANCE

POLICY #: _____ GROUP #: _____

TELEPHONE #: _____

INSURED NAME (As it appears on your insurance card): _____

SECONDARY INSURANCE: _____ or NO SECONDARY INSURANCE

POLICY #: _____ GROUP #: _____

TELEPHONE #: _____

INSURED NAME (As it appears on your insurance card): _____

PLEASE READ THE OTHER SIDE AND SIGN YOUR NAME ♦ THANK YOU

Spine & Sport

AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by appropriately licensed physical therapists, occupational therapists, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologists or other assistants employed by Spine & Sport. Authorization is hereby granted for such treatment and procedures as prescribed by my physician, or directed under California "Direct Access".

I understand and acknowledge that as part of my treatment I will be engaging in physical exercises and using exercise equipment and as with all such physical activity there is an inherent risk of injury or complication to my existing condition. I am voluntarily participating in these physical activities and knowingly and freely assume all risks of injury, loss or damage on account of these activities. I understand that results are not guaranteed and that I have the right to discuss the purposes and risks associated with all recommended treatment procedures and activities with my therapist.

I certify that the information provided to Spine & Sport by me is correct, and I accept full responsibility for all charges*. I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to Spine & Sport, I hereby instruct and direct the Spine & Sport to bill me directly for the insurance payments made to me. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees and/or collection agency commissions or charges.

*Patients with valid workers' compensation claims are not responsible for treatment charges.

MEDICAL RECORDS AUTHORIZATION

Spine & Sport is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or other agency legally involved with my case (proof of relationship will be confirmed).

MEDICARE PATIENTS

I certify that the information provided to Spine & Sport by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize Spine & Sport to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

Patient Signature

Witness

Date

FOR MINORS: As parent or legal guardian, I have read, understand, and agree with all items stated above and hereby authorized Spine & Sport to administer physical medicine treatment as prescribed to _____.

Patient Name

Parent/Guardian Name

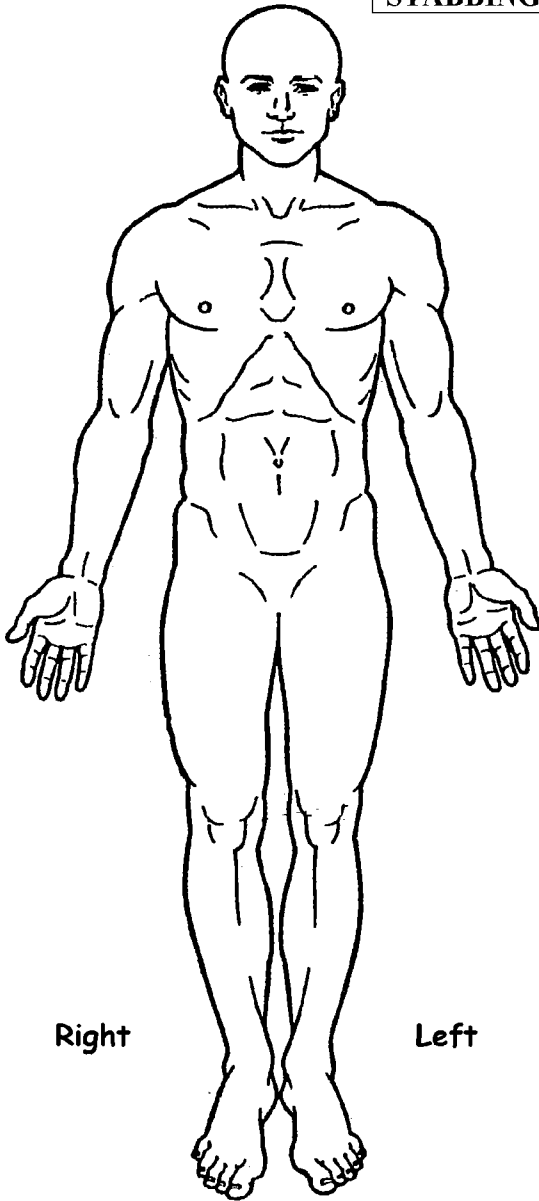
Parent/Guardian Signature

Date

WHERE IS YOUR PAIN NOW?

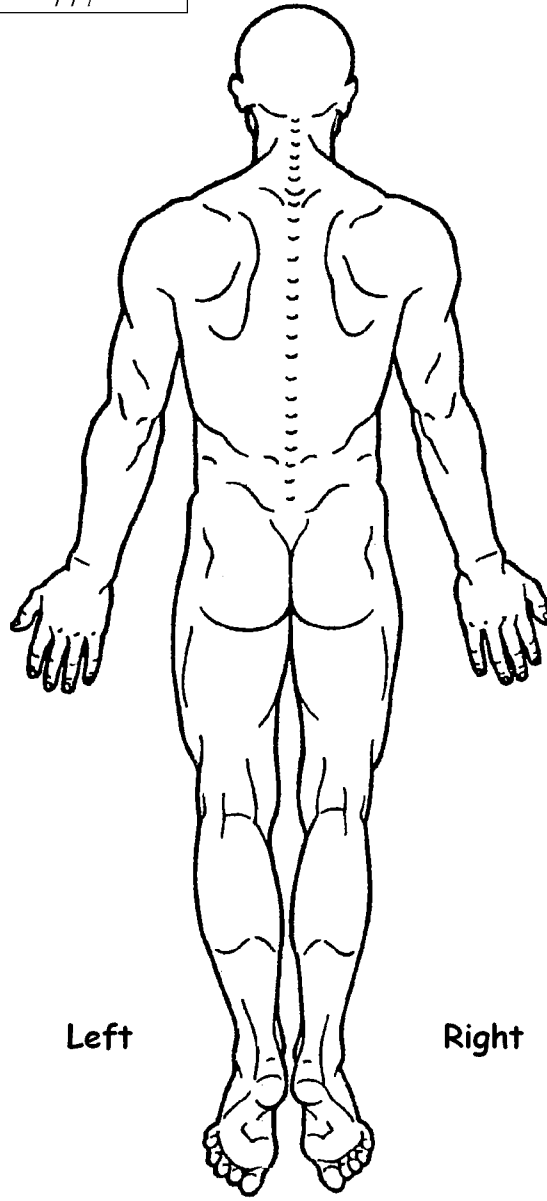
Mark the areas on your body where you feel these sensations:

KEY	
ACHE	AAA
NUMBNESS	OOO
PINS & NEEDLES	---
BURNING	XXX
STABBING	///



Right

Left



Left

Right

PLEASE MARK WITH AN "X" ON THE LINE BELOW THE DEGREE OF PAIN NOW:

NO PAIN

WORST PAIN

SINCE YOUR SURGERY/PROCEDURE, ARE YOU NOW: Better Worse Same

PATIENT NAME: _____

DATE: _____

Patient Medical History and Health Risk Profile

Patient Name: _____ Date: _____
 Age: _____ Height: _____ Weight: _____ Gender: Male Female

Emergency contact:
 Name: _____ Phone: _____
 Relationship: _____

1) Problems to be treated today: _____
 Have you had treatment for this problem before? Yes No When: _____

Please describe the type of treatment: _____

Have you had surgery associated with this problem? Yes No

If so, please list date and type: _____

2) Do you have any other condition that is aggravated by exercise? _____

3) Please list the names of any primary care physician / internist / cardiologist that you are seeing, or have seen in the past:

Name: _____ Name: _____

Phone: _____ Phone: _____

4) Are you currently pregnant? Yes No

5) Do you need assistance with any of the following:

Transportation	Yes <input type="radio"/>	No <input type="radio"/>	Meals	Yes <input type="radio"/>	No <input type="radio"/>
Shopping/Errands	Yes <input type="radio"/>	No <input type="radio"/>	Personal Care	Yes <input type="radio"/>	No <input type="radio"/>
Domestic chores	Yes <input type="radio"/>	No <input type="radio"/>	Other _____	Yes <input type="radio"/>	No <input type="radio"/>

6) Has your illness / disability caused any of the following:

Financial Problems	Yes <input type="radio"/>	No <input type="radio"/>	Family Problems	Yes <input type="radio"/>	No <input type="radio"/>
Emotional Problems	Yes <input type="radio"/>	No <input type="radio"/>	Other _____	Yes <input type="radio"/>	No <input type="radio"/>

7) Do you have or have you had any of the following:

Feel faint or dizzy	Yes <input type="radio"/>	No <input type="radio"/>	Osteoporosis	Yes <input type="radio"/>	No <input type="radio"/>
Frequent pain in heart or chest	Yes <input type="radio"/>	No <input type="radio"/>	Known heart disease	Yes <input type="radio"/>	No <input type="radio"/>
Pacemaker	Yes <input type="radio"/>	No <input type="radio"/>	Diabetes	Yes <input type="radio"/>	No <input type="radio"/>
Headaches	Yes <input type="radio"/>	No <input type="radio"/>	Swollen ankles	Yes <input type="radio"/>	No <input type="radio"/>
Nervous disorders	Yes <input type="radio"/>	No <input type="radio"/>	Kidney problems	Yes <input type="radio"/>	No <input type="radio"/>
Allergies	Yes <input type="radio"/>	No <input type="radio"/>	Heat sensitivity	Yes <input type="radio"/>	No <input type="radio"/>
Seizures	Yes <input type="radio"/>	No <input type="radio"/>	Hernia	Yes <input type="radio"/>	No <input type="radio"/>
Balance problems	Yes <input type="radio"/>	No <input type="radio"/>	Metal implants	Yes <input type="radio"/>	No <input type="radio"/>
Hearing Problems	Yes <input type="radio"/>	No <input type="radio"/>	Vision problems	Yes <input type="radio"/>	No <input type="radio"/>
High cholesterol	Yes <input type="radio"/>	No <input type="radio"/>	High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>
Cancer	Yes <input type="radio"/>	No <input type="radio"/>	Low blood pressure	Yes <input type="radio"/>	No <input type="radio"/>
			Tuberculosis	Yes <input type="radio"/>	No <input type="radio"/>
			Hepatitis	Yes <input type="radio"/>	No <input type="radio"/>

8) Please circle the closest answer or leave item blank if you do not know:

Cigarettes (per day)	Never <input type="radio"/>	1-5 <input type="radio"/>	10-20 <input type="radio"/>	30-40 <input type="radio"/>	>50 <input type="radio"/>
Alcoholic drinks (per week)	Never <input type="radio"/>	1-5 <input type="radio"/>	10-20 <input type="radio"/>	>20 <input type="radio"/>	
Cardiovascular Fitness (per week)	None <input type="radio"/>	Occasional/ <input type="radio"/>	Recreational	3+ days/week for <input type="radio"/>	at least 15 minutes

9) Respiratory Status: Normal Moderate Severe (shortness of breath with mild exertion)

For office use only: I have reviewed the Health Risk Profile and the following is appropriate:

- Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- Further cardiovascular screening is not necessary at this time.

Clinician Signature: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY NOTICE

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office.

It is customary to pay for services at the time they are rendered. For your convenience, payments may be made by cash, check credit card. If you have medical insurance coverage, a determination of your eligibility will be made, followed by a discussion of your benefits as they pertain to your treatment.

_____ 1. **PRIVATE INSURANCE:** Professional services rendered to you (or your dependents) by Spine & Sport are your sole financial responsibility. Spine & Sport will bill your insurance as a courtesy, but you are ultimately responsible for payment for your treatment. You are financially responsible for any and all balances not paid by your insurance (i.e. deductible, co-pay, coinsurance, denied charges, and fees reduced by usual & customary charges). You are required to pay your reported co-payment on the day of your visit. Any other unpaid balance due will be reflected in your monthly billing statement. Please pay close attention to statements received from your insurance company as they may report balances due prior to receiving a statement from our office. Any unpaid charges on an account for 90 days are subject to collections action.

_____ 2. **WORKER'S COMPENSATION:** If you were injured during the course of your employment, please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified with your employer and we will bill the worker's compensation carrier directly.

_____ 3. **PERSONAL INJURY/NO ATTORNEY:** If you were in an accident and you do not have an attorney, you are expected to make consistent payments as you receive treatment. You will be reimbursed for any overpayments should your case settle in your favor and payment is received by another party. You are responsible for your entire treatment cost, regardless of settlement circumstances or amounts. Please ask the front desk for available payment options.

_____ 4. **PERSONAL INJURY/ATTORNEY:** If you were in an accident and are represented by an attorney, we must have a lien on file signed by you and your attorney. This will allow you to receive treatment without payment until your case settles. You are ultimately responsible for your entire treatment cost, regardless of settlement circumstances or amounts.

_____ 5. **CASH:** If you do not have insurance, you will be expected to pay for treatment at the time of service. A discount will be extended if payment is made at the time of service or in advance.

Please direct any additional questions to the business office.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO SPINE & SPORT.

Patient (or Guardian) Signature

Date

Witness Signature

Date

Spine & Sport

HIPAA NOTICE

April 14, 2003

Dear Spine & Sport Patient:

As you may know, the federal government has enacted a new “privacy rule” designed to protect the privacy of your health information. This law applies to physicians, hospitals, other health care providers and health plans. As of April 14, 2003, under this privacy rule we are required to provide you with a copy of our Notice of Privacy Practices which summarizes how we may legally use your health information and also our duty to protect your health information.

Please acknowledge your receipt of the Spine & Sport Notice of Privacy Practices by signing the attached Acknowledgment form. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical records.

Please let the Clinic Director know if you have any questions about our Spine & Sport Notice of Privacy Practices.

Spine & Sport

**ACKNOWLEDGMENT OF RECEIPT OF
SPINE & SPORT NOTICE OF PRIVACY PRACTICES**

By signing this document, I acknowledge that I have received a copy of Spine & Sport Notice of Privacy Practices.

Print Patient Name: _____

Signature of Patient or Legal Representative

Date: _____

If signed by legal representative, please describe relationship to patient:

Spine & Sport

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Clinic Name _____ Clinic Address _____

Phone #: _____ Fax: _____

Patient Name _____ Date: _____

Address _____ SS#: _____

DOB: _____

Receive Records From:

Release Records To:

Please send a copy of my records as indicated for date(s) of Treatment: _____

Operative Records Lab Reports H&P X-ray Reports
 Prenatal Records Discharge Sum Discharge Sum Other

Purpose for releasing medical information _____

**SIGNATURE OF PATIENT, PARENT
OR LEGAL GUARDIAN**

WITNESS

DATE

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

SIGNATURE OF PATIENT

WITNESS

DATE

Permission to FAX records for medical emergency? Yes No

This authorization expires ninety (90) days from the date of this signature.