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

REV0311

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 herby 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

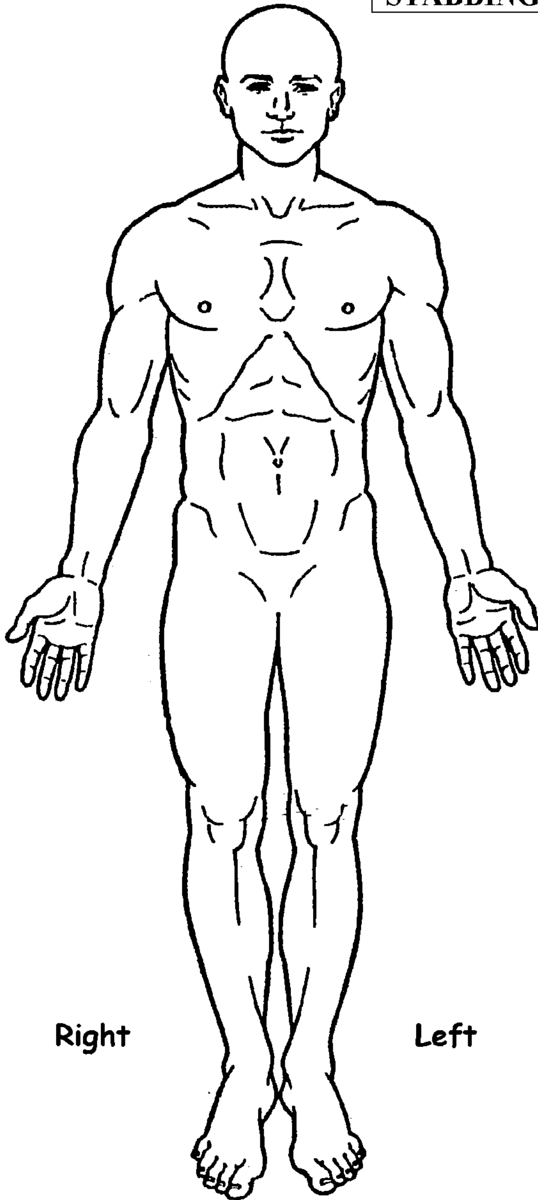
______________________________	______________________________	_______________
Parent/Guardian Name	Parent/Guardian Signature	Date

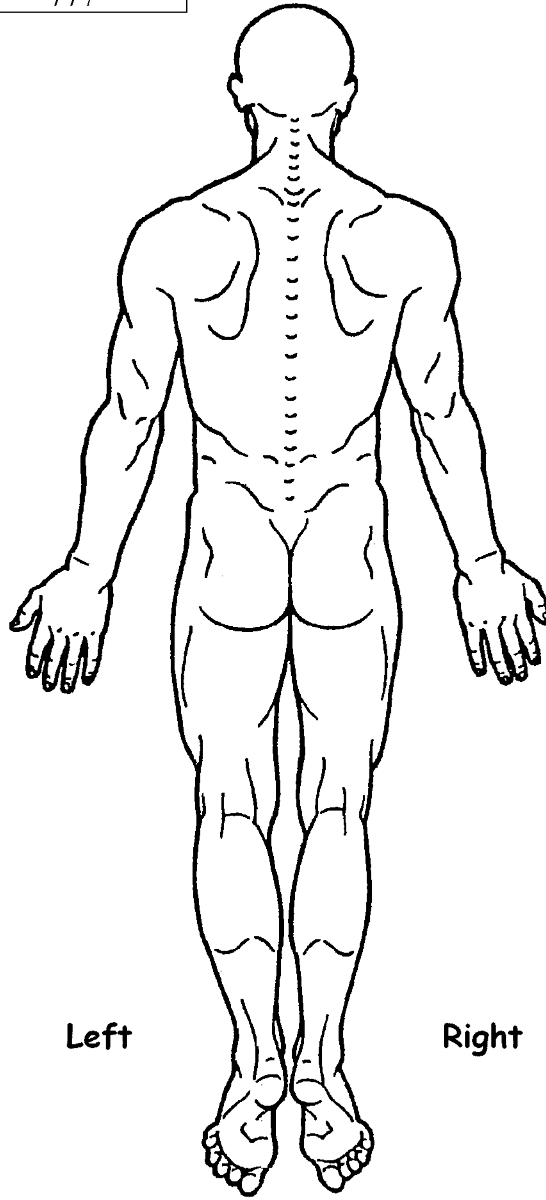
REV1009

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	///





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	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic chores	Yes	No	Other____________	Yes	No

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

Financial Problems	Yes	No	Family Problems	Yes	No
Emotional Problems	Yes	No	Other____________	Yes	No

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

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

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

Cigarettes (per day)	Never	1-5	10-20	30-40	>50
Alcoholic drinks (per week)	Never	1-5	10-20	>20	
Cardiovascular Fitness (per week)	None	Occasional/ Recreational		3+ days/week for 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:

REV0106

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

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.

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: ___________________________

____ Date: ____________________

Signature of Patient or Legal Representative

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.

A. Notifier: C. Identification Number:

B. Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the services listed below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost:
Physical Therapy Occupational Therapy	**Medicare may not pay for Physical or Occupational Therapy services over $1880. Unless your condition qualifies for a cap exception.**	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information: While there is no guarantee your condition often qualifies for an exception to the cap. If medically necessary, we will file a Medicare cap exception.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare Billing, call 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048) Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.