SPINE&SPORT
"An Active Approach to Spinal & Extremity Injuries"
EMPLOYEE OWNED PHYSICAL THERAPY

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			PATIENT DATE OF BIRTH
STREET ADDRESS, CITY, STATE, ZIP			EMAIL ADDRESS
CELL PHONE	HOME PHONE		EMPLOYMENT STATUS ❑ Full time ❑ Part time ❑ Unemployed ❑ Retired ❑ On Leave
SEX ❑ Male ❑ Female	PATIENT SSN	PRIMARY DOCTOR	REFERRING DOCTOR (if applicable)
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS		EMPLOYER PHONE
EMERGENCY CONTACT NAME	PHONE NUMBER		RELATIONSHIP

Are you the primary subscriber on your insurance? ❑ YES ❑ NO →If "NO" then fill out below:

RESPONSIBLE PARTY INFORMATION

The parent/guardian of a minor is responsible for payment of the minor's account balance. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of MDRS Spine & Sport Physical Therapy Inc.

RELATION TO PATIENT: ❑Parent ❑Guardian ❑Other

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)	
DATE OF BIRTH	SSN	PHONE NUMBER

PATIENT FINANCIAL RESPONSIBILITY

❑ Cash/Self-Pay ❑ Insurance ❑ Personal Injury Lien/ Med Pay ❑ Workers' Compensation Date of Injury: _____

I agree to pay MDRS Spine & Sport Inc. all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third-party insurance plan, a third-party payor, or other payor source on my behalf for services rendered. In the event any third party fails to render payment, I understand and agree that I am personally responsible. If my account is referred to a collection agency or an attorney, I further agree to pay all permitted reasonable costs of collection including, without limitation, reasonable attorney's fees.

Initials: _____ Date:_____

Insurance Name: _____ Member ID#:_____

PROFESSIONAL BOUNDARIES AND SENSITIVE TOUCHING

Physical therapy services are provided to improve the patient's overall health and wellbeing. Requests for sexual activity will not be tolerated. Any requests for sexual activity will be reported to the proper authorities. Sexual interaction or discussion of any kind between the patient and the therapist is NEVER appropriate. If the therapist feels threatened or uncomfortable in any way the treatment session will be terminated, and the patient will be asked to leave.

Physical therapy may entail touching of patient by the physical therapist. The physical therapist shall use appropriate clinical techniques and endeavor to avoid touching of any sensitive areas. The breast and genital area will not be massaged under any circumstances and a professional distance will be maintained from these areas.

Patients under the age of 18 must be accompanied by a parent or legal guardian during the duration of therapy treatment session.

HIPAA NOTICE

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 here. 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.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

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, aids, and physical therapy assistants or other assistants employed by MDRS Spine & Sport Inc. Authorization is hereby granted for such treatment and procedures as prescribed by my physician or as 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, death, 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 MDRS Spine & Sport Inc. by me is correct, and I accept full responsibility for all charges*. I hereby assign and authorize payment directly to the abovenamed clinic of all applicable insurance benefits. If my current policy prohibits direct payment to MDRS Spine & Sport Inc., I hereby instruct and direct the MDRS Spine & Sport Inc. 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.

MEDICARE PATIENTS

I certify that the information provided to MDRS Spine & Sport Inc. 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 MDRS Spine & Sport Inc. 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.

In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to Spine and Sport and/or the treating physician through email or text utilizing established security measures. I acknowledge that such film and/or related images will only be used or disclosed for treatment purposes, and that Spine and Sport will not further use or disclose such film or images for any other purpose without my authorization or consent.

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

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

RELEASE OF INFORMATION

I understand that:

- MDRS Spine & Sport Inc. 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).
- 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.

Permission to fax records for medical emergency? ❑ Yes ❑ No

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL) | **DATE:**

Problems to be treated today:

Have you had treatment for this problem before? (ie: injections, PT, chiropractic, acupuncture) ❑ Yes ❑ No If *yes*→ Please describe the type of treatment and when:

Have you had surgery associated with this problem? ❑ Yes ❑ No

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

❑ Do you have any condition that is aggravated by exercise? _____

SOCIAL HISTORY
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled ☐ Student
☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following? *OR* ❑ NONE of the problems listed

❑ Allergies: _____
❑ ALS (Lou Gehrig's disease)
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Arterial fibrillation (A-Fib)
❑ Balance problems
❑ Blood clots
❑ Blood disorder
❑ Brain injury
❑ Cancer: _____
❑ Cardiac arrest
❑ chest pain
❑ Chronic obstructive pulmonary disease (COPD)
❑ Depression
❑ Diabetes
❑ Faint or dizzy spells
❑ Fibromyalgia
❑ Gout
❑ Heart disease
❑ Heat sensitivity
❑ High cholesterol
❑ Hepatitis
❑ Hernia
❑ HIV/AIDS
❑ Hypertension (high blood pressure)
❑ Hypotension (low blood pressure)
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Insomnia
❑ Lymphedema
❑ Memory problems
❑ Migraines
❑ Multiple Sclerosis
❑ Muscular Dystrophy
❑ Neuropathy
❑ Organ injury
❑ Osteoporosis
❑ Parkinson's Disease
❑ Post-traumatic stress disorder (PTSD)
❑ Reynaud's Syndrome
❑ Seizures
❑ Shortness of breath
❑ Sleep apnea
❑ Spinal Cord Injury
❑ Stroke
❑ Tuberculosis
❑ Visual disturbances
❑ Vestibular problems

Medications: List any medications you are currently taking (including over the counter medications): **PLEASE PRINT LEGIBLY**

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

For Clinician only: I have reviewed the Health Risk Profile and the following is appropriate: ❑ Contact MD with cardio vascular Screening Request Form or request results of exercise test within last 2 years; ❑ Further cardiovascular screening is not necessary at this time.

Clinician Signature:

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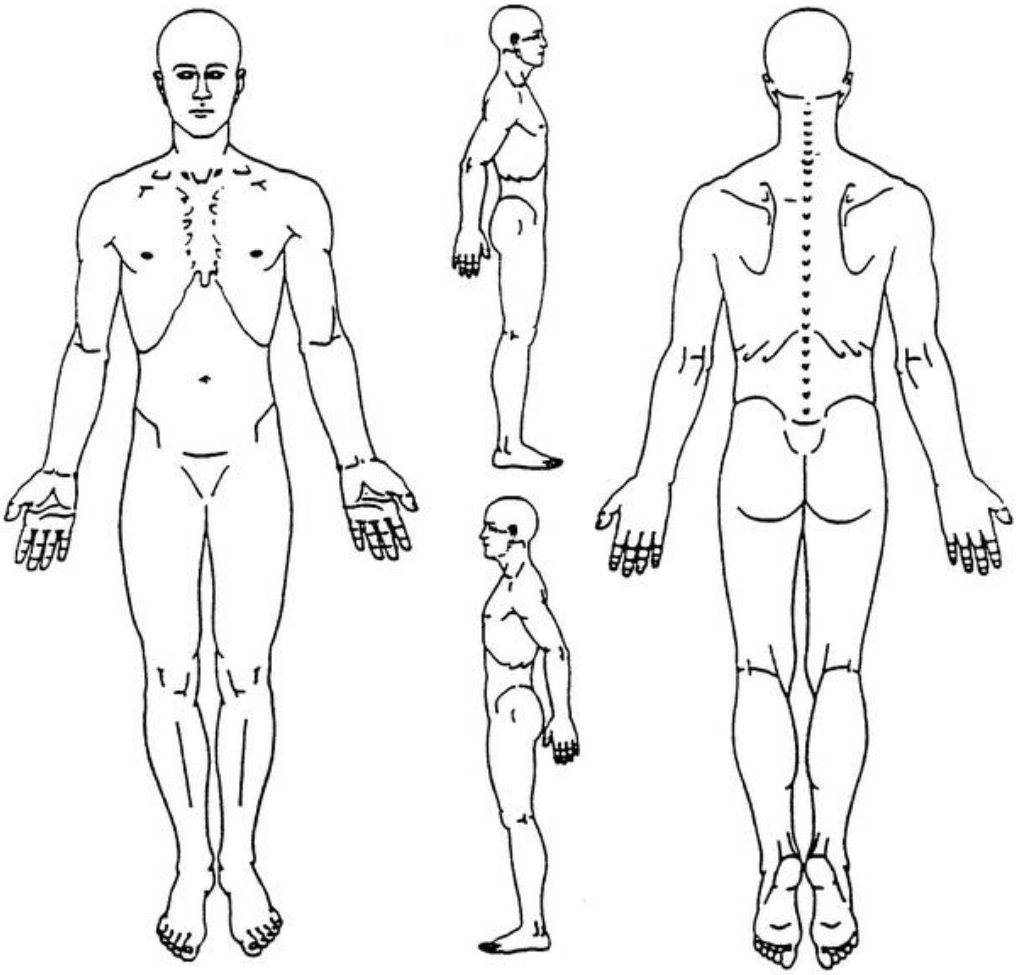
Pain Drawing

Patient Name (Print)_____ Date_____

Patient Signature_____

Please use the diagram below to indicate where you feel symptoms right **now**.



Since your injury/surgery, are you now: ❑ Better ❑ Worse ❑ Same