Sports & Rehab *www.sportsandrehab.com*

Appt. Date________________________

Appt. Time _______________________

Therapist ________________________

____

PATIENT INFO

Last Name______________________________ First ______________________ MI ________

Address ______________________________ City ________________ State _____ Zip ________

Home Phone ________________ Cell ______________ E-mail Address ______________________

DOB ____________________ Age ______________ Social Security # ______________________

Employer______________________________ Work phone ______________________________

Address ______________________________ City ________________ State _____ Zip ________

Spouse's Name __________________________ Cell ________________ DOB ______________

Primary Care Physician______________________ **Referring Physician** __________________

Have you had **PT/OT/ST** prior this year? **Y / N** If Yes, When:_____________________________

BILLING INFORMATION (Please fill out only if insurance card is not available) Medical Ins____ MVA____ WC____ Other____

- **Health Insurance** (Subscriber information please)

  Insurance Co. ______________________________ ID ______________________________

  Insurance Subscriber __________________________ DOB __________ Employer______________

- **Worker's Comp / MVA / Liability** (Please circle one) **Date of Injury** ______________ **Accident State** ____________

  Insurance Co. ______________________________ Address ____________________________

  City ______________________________ State ______________________ Zip Code ________

  Adjustor ____________________ Tel ______________________ Claim # ______________

RESPONSIBLE PARTY INFORMATION (If patient is under 18 years of age)

Name of resp. party __________________________ DOB ________________ Tel ______________

Address (If different than patient) ________________ City ________________ State _____ Zip ________

I give permission to Sports and Rehab to treat my child.

Signature of responsible party ____________________________________ Date__________________

SIGNATURE REQUIRED BEFORE TREATMENT IS RENDERED

- I give permission to Sports and Rehab to render treatment as needed.
- I give permission to release any medical records to Sports and Rehab that is necessary to aid in my treatment.
- I give permission to Sports and Rehab to release therapy records to my physician, insurance company or other related parties (i.e. case nurse).
- A copy of the Bill of Rights and Privacy Notice Policy can be obtained upon request. Copies can also be obtained on our website www.sportsandrehab.com .

Signature of responsible party ________________________________ Date ______________________

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RISK PROFILE

1. Do you smoke? ___________ If so, how many packs per day? ______
2. Is your occupation stressful? ___________
3. Is your occupation physical? ___________ Sedentary ______ Moderately Active ______Very Active ______
4. Are you taking any medications? ___________ If so, please list: ______________________________
5. Do you currently exercise on a regular basis? ___________ ______________________________
6. If female, are you currently pregnant? ___________ How far along? ______________________________

MEDICAL HISTORY (If yes, please check)

Past History

Asthma	( )
Cancer	( )
Diabetes	( )
Epilepsy/Seizures	( )
Heart Trouble	( )
High Blood Pressure	( )
Hypoglycemia	( )
Injuries to Knees or Ankles	( )
Lung Disease of Arteries	( )
Rheumatic Fever	( )
Rhythm Abnormalities	( )
Stroke, Heart Attacks	( )
Varicose Veins	( )

Operations: ______________________________

Other: ______________________________

Present Symptoms

Awaken Short of Breath	( )
Arthritis	( )
Back Pain	( )
Chest Pains	( )
Cough on Exertion	( )
Cough up Blood	( )
Heart Palpitations	( )
Light Headedness	( )
Loss of Consciousness	( )
Shortness of Breath	( )
Swollen Legs	( )

Use more than one pillow for sleep

Allergies ______________________________

Other ______________________________

FAMILY HISTORY

Have any of your blood relatives (parents, sisters, brothers) had/have:

Cancer	( )
Heart Attacks	( )
High Blood Pressure	( )
Heart Operations	( )
Congenital Heart Disease	( )
Diabetes	( )
High Cholesterol	( )

Other ______________________________

CANCELLATION POLICY

Please call Sports and Rehab if unable to attend an appointment (preferable 12 to 24 hours prior) to cancel and/or reschedule. If you miss 3 scheduled appointments consecutively, we reserve the right to discharge you from therapy. You will need to obtain another prescription in order to return.

If you are more than **15 minutes** late for your appointment, it will be left to the discretion of your therapist whether you will be treated.

STATEMENT OF ULTIMATE RESPONSIBILITY

I accept full responsibility for any and all visits that are not covered under my insurance plan and/or have not been authorized by my physician or insurance company.

I agree to pay a copay each visit unless I have set up a payment plan.

I understand that I am responsible for any balance on this account and will pay in a timely fashion. Patient balance over 120 days is susceptible to being sent to Collections, with a 26.5% surcharge fee added.

I authorize payment of all claims directly to SPORTS AND REHAB.

Patient Signature______________________________ Date ______________