NEUROSPORT
PHYSICAL THERAPY

Patient Information

Last Name: _____________________________ First Name_________________________________ M.I. ________

Nickname: **____________________________** ***Date of Birth:*** **____/_____/_____** ***Male:*** **_________** ***Female:*** **_________**

Patient Address: ____ City, State, Zip: _____________________________

Patient's Social Security #: ___________________________________ Marital Status: S__ M __ W __ D__ Other ___

Home Phone: __________________ Cell Phone: ____________________ Email: __________________________________

Name of Employer: _______________________________ Phone: _____________ Employed: FT___ PT ___ Retired ___

Employer Address: ____ City, State, Zip: _________________________

Emergency Contact Name: ______________________________ Phone Number: ___________________________________

Policy Holder (if other than self) or Parent /Guardian:

Last Name: ____________________________ First Name: _______________________ MI: ___ Date of Birth___/___/____

Relationship to Patient: Spouse_____ Parent _____ Other_____ SS#: _____________________Male: ____ Female: ____

Address: ____ City, State, Zip:___________________________

Name of Employer: ____ Employed: FT ___ PT ___ Retired ____

Employers Address: ____ City, State. Zip: ______________________

Medical

Referring Medical Doctor: __________________ Address: __________________________ Date of Last Visit:__/___/_____

Doctors Specialty: ___________________________________ Phone: ____

Insurance

Primary Insurance Company Name: ___________________________ Ins. Phone: ______________________________ Policy Number: ________________ Group Number: _____________ Secondary Insurance: ______________________

Phone: _______________ Policy Number: ________________________ Group Number: ________________________

Workers Compensation (If Applicable)

Workers Compensation Insurance Name: _____________________ Employer (Policyholder) Name: ___________________

Claim Adjuster: __________________ Phone: ____________ Claim Number: _____________ Date of Injury: ___/___/____

Phone: ____________ Fax: _____________ Claims Mailing Address: ____

Accident Related (If Applicable)

Date of Injury: ________ Date of First Symptom: ________ Lawsuit Involved: Yes ____ No ____ Third Party: ___________

Description of Accident:

____

Policy Disclosures

As a courtesy, we will bill your insurance company for applicable rehabilitation services performed. For the convenience of our patients, we also offer select rehabilitation products (typically used at home or work) for purchase at our Centers. Please note we do not bill insurance for these products. Co-pays and/or deductibles are due at the time of services are rendered. The patient is ultimately responsible for any balance that is not paid by insurance.

Please provide us with at least twenty-four-hour notice should you need to reschedule or cancel an appointment otherwise you may be billed your co-pay or a charge of $20.00, whichever is greater. Patients that arrive fifteen minutes or more late may be asked to reschedule their appointment.

A storage area is available to our patients during their visit. Patient items found at the Center will be placed in our lost and found for thirty-days. We are not able to accept liability for any personal items brought to the Center.

We are a smoke and drug free environment.

Consent For Treatment and Benefits

My signature is required below to authorize treatment. My signature also authorizes the release of my medical information (including but not limited to my physician, insurance company, employer, school, related healthcare provider, nurse case manager, attorney, assignees, beneficiaries, and all other related persons to my treatment) that is needed to process my claim. I also agree to a direct assignment of my benefits to Neurosport Physical Therapy and Rehabilitation Specialist, Inc. d/b/a Neurosport Physical Therapy where a claim has been filed, the payment of medical benefits directly to this practice for services rendered, and to comply with the above policies. We reserve the right to change our policies without prior notice.

I am aware of my diagnosis and voluntarily consent to treatment at this practice. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging. No guarantees have been made to me about the outcome of care provided at this practice. I agree to pay for the services rendered and to cooperate in providing information necessary to process my claims(s) with third-party payers. Where the law or my insurance contract does not prohibit payment by me, I accept responsibility to pay any and all of my account balances (even if the balance differs from the benefit verification form is not a guarantee for coverage). A photo carbon copy of this agreement shall be as effective and valid as the original. All information provided on this document is accurate to the best of my knowledge.

Patient Signature: ____ Date: ________________________________

Parent/Guardian's Signature: ____________________________ Print Name: _________________________________

Authorization for the Release of Medical Record Information

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Neurosport Physical Therapy & Rehabilitation Specialist, Inc. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment.

Patient Signature: ____ Date: ________________________________

Parent/Guardian's Signature: ____________________________ Print Name: _________________________________

Benefit Disclaimer

It is the patient/insured person's sole responsibility to know their outpatient physical therapy benefits. Neurosport Physical Therapy is not required to contact your insurance company but does as a courtesy.
Neurosport Physical Therapy may contact your insurance prior to your initial visit to verify coverage. The information received is not a guarantee of payment. Patients are expected to know their plan benefits and limitations prior to their initial visit.
Neurosport Physical Therapy is bound contractually to accept negotiated rates with contracted insurance carriers and all copays. Co-insurance and deductibles are to be paid at the time of service.
If a payment plan is needed please discuss with the front desk coordinator prior to treatment.
Neurosport Physical Therapy does accept all major credit cards, checks, cash and debit cards.

Patient Signature: ____ Date: ________________________________

Parent/Guardian's Signature: ____________________________ Print Name: _________________________________

HIPPA Release Form

I, _______________________________ (Print Name), authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:
Spouse: ____
Child(ren): ____
Other: ____
Information may be released to anyone

This release of information will remain in effect until terminated by patient or parent/guardian in writing.

Messages:

Please call: ___ Home ____ Cell ____ Work
If unable to reach me:
___ May leave a detailed message ___ Ask me to return your call ___ Do not leave a message

Patient Signature: ____ Date: ________________________________

Parent/Guardian's Signature: __________________________________ Date: ________________________________

How did you hear about us? Please check all that apply.

____ Referred by Physician

____ Internet Search/Magazine/Newspaper

____ **NASA/TOPHAT**

____ **GU Soccer**

____ **Youth Rugby**

____ **Roswell Soccer**

____ High School: ________________________________

____ Familiar with our Location

____ Previous Patient

____ Friend: ________________________________

____ Other If so, please state: ____________________

Name:

NEUROSPORT
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Your medical history is very important to us to ensure your safety during the rehabilitation process. Please be as complete as possible with your answers and feel free to discuss your history with your therapists.

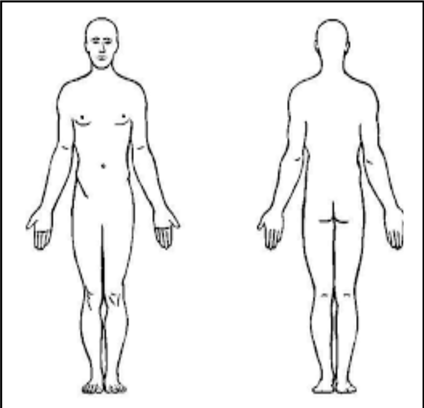
Please provide:
Age: _____
Height: _____
Weight: _____

Current Medications: ______________________________
____
____
____

Please rate your pain.
(0 is no pain while 10 is maximum)
_____/10

Do you have a history of the following?

	Yes	No		Yes	NO
Diabetes	______	______	High Blood Pressure	_____	_____
Heart Disease	______	______	Stroke	_____	_____
Cardiac Pacemaker	______	______	Lung Disease	_____	_____
Cancer	______	______	Falling 1 or More Times	_____	_____
Gastrointestinal Disease	______	______			



Please circle the areas that are painful

Please list any significant surgeries you have had in the last 5 years.
____
____
____

Which diagnostic test(s) have been performed for your current condition and where were they done?
____ X-ray ____ CT ____ MRI ____ Blood Work ____ NCV/EMG Other: ____________________

Have you received physical therapy or hand therapy for your current condition? Yes ____ No _____
If yes , Where and for how long? ______________________________

Have you experienced any of the following?

	Yes	No		Yes	No
Persistent pain at night	______	______	Frequent nausea or vomiting	______	______
Fever or night sweats	______	______	Recent unexplained weight loss	______	______
Are you pregnant	______	______	Frequent or severe abdominal pain	______	______
Loss of appetite	______	______	Unusual menstrual irregularities	______	______
Shortness of Breath	______	______	Frequent heartburn or indigestion	______	______
Dizziness	______	______			

Other Medical History: ______________________________
____
____
____