Elite Physical Therapy Sports Performance

LEGAL First Name_____ Preferred Name: _____Date of Injury:_____Date:_____

Last Name _____ DOB _____ Age_____ Sex: M F

Street Address_____ City_____ State_____ ZIP_____

Marital Status: *Single* *Married* *Divorced* *Widowed*

How did you hear about us? _____

Email Address _____ SS# __ __ __ - __ __ - __ __ __ __

Home Phone ( ) _____-_____ Cell Phone: ( ) _____-_____

Employer _____ Work Phone ( ) _____- _____

Injury Area _____ Accident Related? *Yes* *No* If "Yes", *Auto* or *Work*

Emergency Contact: _____ Phone ( ) _____-_____

_____ **Please initial if you would like to give us permission to leave a voice message regarding your insurance and billing information.**

_____ **Please initial if you would like to give us permission to leave a voice message regarding your medical information.**

Are you receiving or have you recently received home health care services? *Yes* *No*

Are you receiving or have your recently received other therapy services? *Yes* *No*

Please initial after reading the following statements:

1. _____**Consent to Treatment:** I consent to rehabilitation and related services at Elite Physical Therapy and Sport Performance. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involved bodily contact touching and/or direct contact of a sensitive nature.
2. _____**Treatment of a Minor:** I, as the custodial parent/guardian of a minor receiving treatment hereunder, do by agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. I understand I am financially responsible for the patient.
3. _____**Liability**: I know and agree that Elite Physical Therapy and Sports Performance is not responsible for the loss or damage to personal valuables.
4. _____**Authorization of Payment**: I hereby assign all benefits directly to Elite Physical Therapy and Sports Performance and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as other permitted or required in the Notice of Privacy Practices. I understand fully that in the event any insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment.

Patient Signature:_____Date:_____

Medical History

Date: _____

Patient Name _____ DOB_____

Primary Care Physician_____ Referring Physician _____

Other Physician(s) to whom you want a report sent _____

Occupation_____ Retired? _____*Yes* _____*No* Disabled? _____*Yes* _____*No*

Do you drink alcohol? _____*Yes* _____*No*

_____History of Alcoholism _____*Less than 7 drinks per week* _____ *More than 7 drinks per week*

Do you smoke? _____*Yes* _____*No*

Do you exercise? _____*Unable* _____*Sedentary* _____*Occasionally* _____*Active* _____*Regularly*

Within the ***last 24 hours*** have you experienced the following symptoms? (check all that apply)

_____ Fever
_____ Chest Pain
_____Palpitations
_____ Rashes
_____Skin Sores
_____Excessive Thirst
_____Excessive/Frequent Urination
_____Burning Urination
_____Shortness of Breath

In the past, have you experienced any of the following? (check all that apply)

_____ Recent weight loss/gain
_____Depression
_____Anxiety
_____Easy Bruising
_____Easy Bleeding
_____Sensitivity to Latex

Please check all that apply:

_____**Have you ever had heart surgery or a pacemaker?**
Please explain:_____
_____**Are you currently taking Plavix, Coumadin or Aspirin?**
_____**Do you have a history of DVT/PE (Blood clot in the leg or lung)?**
_____**Are you on any Rheumatoid Arthritis drugs?**
_____**Do you have a Latex Allergy?**
_____**Are you Diabetic?**
_____**Do you have a history of cancer or are you currently being treated for cancer?**
Please explain: _____

Please list ***all medications*** _____(OR check here to see attached list)

1. _____
2. _____
3. _____
4. _____

Please list ***all allergies***:

_____
_____
_____

Please list ***all medical problems***:

_____
_____
_____

Please list ***all surgeries*** you have had:

_____
_____
_____

Elite Physical Therapy and Sports Performance
4177 Village Park Drive, Suite B
Traverse City, MI 49685
Phone: 231-421-5805 Fax: 231-421-5308

Consent Form

HIPAA Privacy Notice

I understand that, under Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. Elite Physical Therapy and Sports Performance's *Notice of Privacy Practices* has been made available to me, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of this notice. In accordance with the *Notice of Privacy Practices*, I authorize Elite Physical Therapy and Sports Performance to administer physical therapy services. I understand medical information concerning my treatment may be released to my insurance carrier, referring and/or primary physician.

_____Initial

Receipt of Payment Policy

I acknowledge the receipt of the Elite Physical Therapy and Sports Performance Payment Policy. I authorize Elite Physical Therapy and Sports Performance to directly bill my health insurance carrier(s) on my behalf to process insurance claims. I understand I am financially responsible for all co-payment, deductibles, and non-covered services at the time of service. I further request direct payment from health insurance carrier(s) to Elite Physical Therapy and Sports Performance which accepts assignment of benefits.

_____Initial

Authorization to Release Information to Family/Friend

I authorized the provider to release medical information and evaluation finding to family members/friends listed below:

_____Relationship:_____Phone:_____

(Print Name)

_____Relationship:_____Phone:_____

(Print Name)