ProSport
PHYSICAL THERAPY & PERFORMANCE

Patient Registration Form— *Shaded Areas, Office Only*

Date:

Primary Insurance: Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____				**Secondary Insurance:** Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____	
☐ New Patient ☐ Re-Start ☐ New Diagnosis ☐ New Insurance				**PTPN** ☐ Yes ☐ No	
Patient #	Title	Patient Name (Last, First, Middle Initial)			
Address		City/State/Zip			
Home Phone ( )	Work Phone ( )	Cell Phone			
Social Security #	DOB	Gender ☐M ☐F	Driver's License #	Insurance Type *PPO, HMO, Medicare, etc*	Email .
Referring Physician	Referring NPI (10 digits)	Referring Physician Phone# (	Treating Therapist		
Patient Status ☐ Active ☐ SFA	Primary location CLINIC	Marital Status	Student Y ☐ N ☐	Employment Status	
Occupation	Employer	Employer Phone #			
Address	City/State/Zip				

Are you currently receiving healthcare service through a Home Health Agency (HHA)? ☐ Yes ☐ No

If **yes**, please provide name and phone number of the HHA. _____

Emergency Contact (Name)	Home Phone ( )	Work Phone ( )
Address	City/State/Zip	Relationship to Patient

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)			Relationship to Patient
Address			City/State/Zip
Home Phone ( )	Work Phone ( )		Email Address
Social Security #	DOB	Gender ☐M ☐F	Driver's License #

Injury Information

Is condition surgery related? ☐ Yes ☐ No	Date of Surgery	Surgical Procedure	
Is condition accident related? ☐ Yes ☐ No	Was an automobile involved? ☐ Yes ☐ No	Date of Accident	
Describe Accident/Injury/Illness			
Were you injured on the job? ☐ Yes ☐ No	Date of Injury	Are you currently working? ☐ Yes ☐ Full-time ☐ Part-time ☐ No	
Name of employer at time of accident	City, State, Zip Code		
Is litigation (lawsuit) involved? ☐ Yes ☐ No	Name of Attorney	Phone # ( )	

-Office Use Only-	
Diagnosis:	**ICD-9 Code:**
Diagnosis:	**ICD-9 Code:**

Insurance Information

Were benefits and authorization verified? ☐Yes ☐No

Primary Insurance In- network ☐ Out-of-network ☐				Pre-Certification ☐Yes ☐No	Visits per Year
Claims Mailing Address	City, State, Zip Code				
Subscriber Name	Date of Birth	Sex ☐M ☐F	Relationship to Patient		
ID Card # (including alpha prefix)	Group #	Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty $	Visits Remaining
Deductible	Out of Pocket				
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone #		

Secondary Insurance In- network ☐ Out-of-network ☐						
Claims Mailing Address	City, State, Zip Code					
Subscriber Name	Date of Birth	Sex ☐M ☐F	Relationship to Patient			
ID Card #(including alpha prefix)	Group #	Authorization #				
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay $	Pre-Certification ☐Yes☐No	Visits per Year
Deductible Start Amount $	Deductible Remaining Amount $			Pre-Certification Phone # ( )		
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone # ( )			

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by ProSport Physical Therapy and assigns to ProSport Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes ProSport Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or ProSport Physical Therapy for payment of charges to the patient.
4. ProSport Physical Therapy reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for ProSport Physical Therapy.

Patient Signature:		Date:
CPM Office Use Only:	*Entered by:*	*Date:*

Policies and Procedures

Thank you for choosing ProSport Physical Therapy as your provider. The following are statements of our Financial and Office Policies which we require you to read and sign prior to any treatment. All patients must complete the Client Registration and Medical History forms before seeing a therapist.

Consent to Therapy: I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist. In order for PT to be effective I must attend as prescribed and scheduled and comply with the home treatment program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist. I realize I have the right to refuse any treatments or procedures I do not agree to.

Insurance Coverage Notice: Our office verifies insurance coverage as a courtesy to our patients. We are not responsible for any misinformation or changes in your policy that result in your financial responsibility being greater than what we quote you. It is the responsibility of all patients to understand their coverage and benefits. We will bill your personal insurance carrier solely as a courtesy to you. You are ultimately responsible for the timely payment of your account. **If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit payment(s) to us.** If formal collection procedures become necessary, you will be responsible for any additional costs.

Cancellation and No-Show Policy Notice: Continuity of care is an important aspect of physical therapy care. Frequent cancellations or failing to show for appointments impacts the effectiveness of your treatment as well as other patient's timely access to care. We strive to provide quality care but your cooperation in keeping your scheduled appointments is exceedingly important. Please arrive a few minutes early if you need to update insurance information, make co-payments or have any other matters with the front office staff. This ensures you and subsequent patients therapy sessions start on time. Our policy on appointment cancellations and no shows are as followed:

- **Cancellations:** We request at least 24 hours' notice if you are unable to make your appointment.
- **No Shows:** If during the course of treatment, you no show for 2 consecutive appointments or 4 appointments total, a discharge note will be sent to your referring physician and further treatments will be terminated.
  Cancellations within 24 hours of appointment AND No Shows are SUBJECT TO A $40 FEE

Notice OF Privacy Practices: I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain Payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical therapist certifications

I have received, read and understand your *Health Information Privacy Notice* containing a more complete description of the uses and disclosures of my health information. I understand that ProSport Physical Therapy has the right to change its *Health Information Privacy Notice* from time to time and that I may contact my local clinic at any time to obtain a current copy of the *Health Information Privacy Notice.*

I acknowledge that I have read and fully understand the above general consent form. Any questions I have had have also been answered to my satisfaction.

_____ _____

Signature of Patient (or Parent/Guardian) Date

_____ _____

Witness (Signature of ProSport Staff) Date

Patient Acknowledgement Receipt to

Notice of Privacy Practices and Consent/Limited Authorization and Release Form

Date: _____ **Account Number:** _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility via email (a physical copy can be obtained by request). Copies of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVICE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE or CONSENT FOR DATA TO BE EXCHANGED ELECTRONICALLY BETWEEN PROVIDERS/HOSPITALS**

_____ _____

Patient Printed Name **Patient Signature**

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA?

_____ First Name Only _____ Proper Sur Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(this includes step parents, grandparents and any care takers who can have access to this patient's records)

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH VIA (choose only ONE point of contact):

Home Telephone _____

____ OK to leave message with detailed information

____ Leave message with call back number ONLY

Cell Phone _____

____ OK to leave message with detailed information

____ Leave message with call back number ONLY

Work Telephone _____

____ OK to leave message with detailed information

____ Leave message with call back number ONLY

***Office Use Only:** I attempted to obtain the patient's signature on this Acknowledgement but did not because (please describe): _____

ProSport Employee Signature: _____

Medical History Form

Name: _____ **Age:** _____ **Today's Date:** _____

Occupation: _____ How did you hear of ProSport? _____

Doctor's Name: _____ Height/Weight: _____ Have you fallen in the last year? **YES/NO**

Where is your pain (body part)? _____ Date of Injury/Surgery: _____

Please describe your injury history or onset of this condition: _____

Have you had any treatment for this condition? **YES/NO** if YES, where? _____

Did you have any of the following tests? __ X-RAY __ MRI __ CT Scan __ EMG __ Other _____ When (date): _____

Please rate the worse pain you've experienced on the following scale: **(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe)**

Is your pain: sharp/ burning/ aching/ tingling/ numbness/ other _____

Does pain radiate into arms and/or legs? **YES/NO** Does rest relieve your pain? **YES/NO** Does pain awaken you? **YES/NO**

Please list any leisure activities: _____

What aggravates your pain? sitting/ standing/ walking/ other _____

What helps reduce your pain? _____

Please list any medications you are currently taking: (we can copy and attach a list if needed)

Name:	**Frequency:**	**Dosage:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently experiencing or have you experienced any of the following?

Diabetes	**YES/NO**	Kidney problems	**YES/NO**	Recent fever	**YES/NO**
High Blood Pressure	**YES/NO**	Nervous disorders	**YES/NO**	Recent Nausea/Vomiting	**YES/NO**
Heart Arrhythmia	**YES/NO**	Stroke	**YES/NO**	Recent weight gain or loss	**YES/NO**
Heart disease	**YES/NO**	Pregnant/IUD	**YES/NO**	Shortness of breath	**YES/NO**
Heart Attack	**YES/NO**	Allergies/Skin disorders	**YES/NO**	Asthma	**YES/NO**
Pacemaker	**YES/NO**	Hernia	**YES/NO**	Headaches	**YES/NO**
Seizures	**YES/NO**	Metal Implants	**YES/NO**	Cancer	**YES/NO**

Injured in a motor vehicle accident **YES/NO** Unrelated previous surgeries **YES/NO** Other _____

If yes to any of the above, please explain and give approximate dates: _____

Patient Signature: _____ **Date:** _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses.

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