SPORTS & MORE PHYSICAL THERAPY, INC.

Patient Intake Information

Date _____

(If you are a returning patient please review the information below and make any corrections or updates and initial where designated.)

Full Name: _____
Last First Middle Suffix Nickname

Address: _____
Street Address or Box City State Zip

Phone: _____
Home Work Cell
(Please include area code. Please indicate best number to reach you during business hours with an *

Patient Info: _____ **Part-time student Full-time student**
Date of Birth Age Social Security # Employed

◉ Male ○ Female ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: _____ **Relationship** _____
Name Daytime phone #

Patient's Email : _____

Would you like for us to email you reminders for your follow up appointments? ☐ **yes** ☑ **no**
Would you like for us to text you reminders for your follow up appointments? ☐ **yes** ☐ **no**

If patient is a minor: _____
Parent/Guardian's: Name Best phone number to call Email

_____ ***All of the information above has been reviewed.*** _____
Initials ***Date***

Problem Area(s) (Please be specific – right/left/both)_____

_____

Is your treatment here a result of an injury? ○ **Yes** ◉ **No** **If yes, date of injury:** _____
Mo/Day/Year

Type of Injury: ☐ **Work** ☑ **Auto** ☐ **Other**

Describe how your injury occurred: _____

Referring Physician/Provider: _____
(Name of Provider and Practice)

How did you hear about us? Internet/Web Page **Other** _____

_____ ***All of the above information has been reviewed and updated.*** _____
Initials ***Date***

INSURANCE/PAYMENT INFORMATION

Do you plan to file Worker's Compensation? ○ **Yes** ○ **No** **Claim #** _____

If yes, give employer's name: _____ **Adjuster's name:** _____

Who should we call to verify?_____
Name and phone number (with area code).

INSURANCE/PAYMENT INFORMATION, Cont'd. - Please provide insurance card to our admin staff.
Primary Policyholder:

_____

Name **Date of Birth** **SS#** **Relationship to Patient**

Is this an HSA or HRA account? ◯ Yes ◯ No If yes, which is it? ☐ HSA ☐ HRA

Responsible Party - Name_____ Relationship to Patient _____
(Person who is responsible for patient's portion of payment due)

_____ ***The above information has been reviewed and updated.*** _____
Initials ***Date***

AGREEMENT & AUTHORIZATION – Please initial each line.

_____ **I hereby authorize Sports & More Physical Therapy, Inc. to perform all necessary physical therapy treatments deemed appropriate by the evaluating physical therapist for my condition and/or recommended by my physician.**

_____ **I understand that if services provided by Sports & More Physical Therapy, Inc. are not authorized by my insurance company or Worker's Compensation I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered.**

_____ **I understand that my insurance benefits will be verified by a Front Office Staff Member of Sports & More Physical Therapy, Inc. prior to my first appointment and reviewed with me. I also understand that verification of benefits and/or confirmation of authorization DO NOT guarantee payment by my insurance and that eligibility and benefit determination will be made once the insurance claim is received and processed by my insurance company.**

_____ **I hereby authorize and request my referring or physician or health care provider to release to Sports & More Physical Therapy, Inc. pertinent medical records.**

_____ **Sports & More Physical Therapy, Inc. is authorized to release to my insurance company, attorney(if applicable), or adjuster (if applicable) any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Sports & More Physical Therapy, Inc. is also authorized to release medical information to my referring physician or health care provider to monitor progress.**

_____ **I hereby authorize and direct my insurance company or companies to make direct payment to Sports& More Physical Therapy, Inc. under any and all applicable coverage, including major medical, for covered charges for services rendered.**

_____ **I have been given an opportunity to review the Notice of Patient Information Practices, Rights and Responsibilities for Sports & More Physical Therapy, Inc. (as required and updated by the HIPAA on November 1, 2013).**

_____ **I authorize Sports & More Physical Therapy or a designated representative to contact me or any person named on the Patient Consent Form and leave messages regarding appointments, account balances, or clinical questions by calling any telephone number provided on this form.**

_____ **I have been given a copy of the Patient Orientation Form for Sports & More Physical Therapy, Inc.**

_____ **I understand that there is a $25 Missed Appointment Charge for any appointment that is missed or cancelled in less than 24 hours previous to appointment time.**

_____	_____	_____
Patient Name (*please print*)	**Parent/Guardian (Print)**	**Date**
_____	_____	
Patient/Parent Signature	**Witness**	

Returning Patients Only – I believe all of the above information to be true.

_____	_____	_____
Signature	***Date***	***Witness***