Welcome to SPORT Clinic Physical Therapy!

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ___
Address: _____ City: _____ State: ___ Zip Code: ____
Mobile Phone: _____ Work/Home Phone: _____
Birth Date: _____/_____/_____ Email: _____

Thanks for choosing SPORT Clinic! How did you find us?

- ☐ My doctor referred me to SPORT Clinic. Provider's Name: _____
- ☐ I heard about SPORT Clinic from: _____

Primary Care Provider: _____

Primary Insurance – Please notify the front office immediately if your insurance changes.
Insurance Company: _____ Relationship to patient:_____
Policy Holder's Name: _____ Policy Holder DOB: _____
ID #: _____ Group #: _____

Secondary Insurance – Medicare patients must complete this section.
Insurance Company: _____
Policy Holder's Name: _____ Relationship to patient: _____
ID #: _____ Group #: _____

Emergency Contact
First Name: _____ Last Name: _____
Mobile Phone: _____ Relationship to patient: _____

▹ I consent to have billing statements, appointment reminders, and responses to my correspondence sent to the patient's **email address** or phone number **voice message** or **text message**. Expect 1-2 text messages/month with a very brief survey to provide feedback. Message and data rates may apply. I understand SPORT Clinic is not responsible for the security of these correspondences. ***Initial*** your response: ____ YES. ____ NO; email / voice / text

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Please **INITIAL**:
___ I give SPORT Clinic providers consent to provide Physical and/or Occupational Therapy.
___ I acknowledge that a 24-hour notice is required for cancellation of scheduled appointments. Notice of less than 24 hours (or no show) will require a $50.00 cancellation fee.
___ I read and understand the: Release of Information Statement, Payment Agreement Statement, and HIPAA Statement.
___ I authorize my insurance benefits to be paid directly to SPORT Clinic Physical Therapy. I understand that I am financially responsible for any balance. I also authorize SPORT Clinic Physical Therapy to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

By completing patient intake forms, you agree to the following:

Assignment and Authorize for Release of Information Statement

▹ I certify the information given by me is correct and complete; SPORT Clinic Physical Therapy is not responsible for misinformation, exclusions, limitations, and non-covered services. SPORT Clinic Physical Therapy is authorized to furnish and release to the Social Security Administration, carriers, intermediaries, or third party agents professional and clinical information as needed for the processing of my medical claims. SPORT Clinic Physical Therapy is released from all legal liability that may arise from the release of this information.

▹ I request that payment of authorized benefits be made on my behalf directly to SPORT Clinic Physical Therapy. I understand that it is my responsibility to verify that SPORT Clinic Physical Therapy is a participating provider for the physical/occupational services provided to you. I understand that I am financially responsible for all charges not covered or paid by my insurance company. I acknowledge full responsibility for understanding my insurance benefits. I understand that prior authorization may be required and that I am responsible for full payment of services when authorization is denied. I further understand that SPORT Clinic Physical Therapy does not accept responsibility for negotiating a settlement on a disputed claim.

Payment Agreement Statement

▹ I agree to pay co-payments, deductibles, and coinsurance amounts and equipment charges as outlined by my insurance plan. Co-payments are due at the time of service. SPORT Clinic issues monthly statements that are expected to be paid in full within 15 days. Monthly late fees of 1% (12% per year) of the outstanding balance apply. Payment plans may be arranged, without fees, upon request. In the event that debt collection services are initiated, the patient will be responsible for the fee for the recovery services (approx. 25-45% of the total debt). All debt handed over to collection will result in credit bureau reporting within the time frame allowed by state law. In the event that legal action is initiated, the patient will be responsible for all fees associated with legal action in addition to the original debt.

HIPAA Statement

▹ HIPPA (Health Information & Patient Privacy Act): The Privacy Policy for SPORT Clinic Physical Therapy regarding the use and disclosure of personal health information is posted in the waiting room. If you have questions, wish to request individual alterations to it, or feel your privacy has been violated at any time, please speak with our front office manager (Michelle).

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ___

Birth Date: _____/_____/_____ Height: _____ Weight: _____

Occupation: _____

My work involves (✓): ___ Sitting ___ Standing ___ Light labor ___ Heavy labor

Leisure Activities: _____

Current exercise habits (✓): ___ None ___ 1-2x/wk ___ 3-4x/wk ___ 5+ x/wk

Current stress level (✓): ___ Low ___ Medium ___ High

Alcohol: ___ drinks per week. Coffee/soda: ___ drinks per week. Smoking: ___ packs per day.

Please check which conditions apply to you:

Condition	Yes	No	Comments
Latex allergy			
Other allergy			
BLOOD PRESSURE			
Hypertension - high BP			
Hypotension - low BP			
HEART & CV DISEASE			
Heart attack/MI			
Atherosclerosis			
Heart murmur			
Stroke			
Pacemaker			
LUNGS			
Asthma			
Emphysema			
COPD			
Shortness of breath			
OTHER CONDITIONS			
Muscle or joint condition			
Diabetes			
Rheumatoid arthritis			
Cancer			
Parkinson's disease			
Multiple sclerosis			
Epilepsy			
Fibromyalgia			
Hearing loss			
Poor eyesight			
Dizziness and/or fainting			
Other (please explain)			

Are you currently **pregnant**: ___ YES ___ NO. **If yes**, what week? _____

List all **current medications** (or provide a list): _____

_____

List **prior surgeries** (including dates): _____

_____

Have you had PT/OT before: ___ YES ___ NO. **If yes**, when/why? _____

What brings you to the clinic **today**? _____