WELCOME to SPORT Clinic Physical Therapy

We hope your experience here is a positive one!

Please let us know if you have any questions, concerns or suggestions about your care.

Length and Frequency of Appointments:

Each physical therapy visit will vary in length, depending upon your insurance coverage. Your therapist will inform you of how often they would like to see you. We **highly recommend that you schedule your appointments as far as possible** for your convenience and preferences.

Cancellations/No Show Policy:

Patients who cancel less than 24 hours before their appointment, or do not show without any notification, **will be billed $35.00 after their first offense**. If a patient continues to cancel without 24 hour notification or no shows, the person **will be billed at $50.00 per cancellation**.

Follow-up Appointments with your Doctor:

It is crucial that we maintain a communication line with your doctor about your progress while in physical therapy, **especially if your doctor referred you to physical therapy**. For your convenience, we will fax the necessary information to your doctor. However, you are responsible for making follow up appointments with your doctor.

Insurance Questions and Fees:

Please ensure that you understand your insurance coverage, physical therapy services cannot be provided without your complete insurance information. **Please notify the front desk immediately if you have any changes to your insurance.** On your first appointment, you will be informed about your insurance benefits regarding physical therapy that is rendered at SPORT Clinic.

Extra Services/Supplies and Payment:

If utilized, you will be billed for the following: electrode pads ($10 per set of 4), exercise tube/band ($6.34 per tube/band), heel lift ($6.34 per lift), traction ($30 for lumbar, $20 for cervical), dry needling ($55 per session) and taping with payment depending on how much of the tape is used. These are non-covered services; therefore, insurance will **not reimburse** these charges. However, a health savings account may be used for these services.

COVID 19:

SPORT Clinic is taking extra precautions to prevent the spread of COVID 19, including health history review and enhanced sanitation/disinfecting procedures in compliance with CDC guidance. By signing below, I agree to comply with a screening at each visit to the clinic and release SPORT Clinic Physical Therapy from any and all liability from unintentional exposure or harm due to COVID-19.

Anti-discrimination policy:

We strive to make the environment at SPORT Clinic safe and comfortable for all patients and staff. We have a zero-tolerance policy for discrimination of any kind, including racist or sexist remarks. SPORT staff reserve the right to ask you to leave the facility if we feel this policy has been violated.

I have read and understand the information above:

Signature: _____ Date: _____

Mequon
10620 N. Port Washington Rd., Suite 202
Mequon, WI 53092

Cedarburg
7269 State Road 60.
Cedarburg, WI 53012

414.351.5794 www.sportclinicpt.com

PATIENT INFORMATION		**EMAIL ADDRESS:_____**	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	___ Male ___ Female	
Home Phone: ( ) -	Cell Phone: ( ) -		
Chose Clinic Because/ Referred to Clinic By:			

CARE PROVIDER INFORMATION	
Referring Dr:	
Regular Dr./PCP	

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	Date of Accident:
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ___ Self ___ Spouse ___ Child ___ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ___ Self ___ Spouse ___ Child ___ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ___ Auto :	___ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

IN CASE OF EMERGENCY		
Name:		
Relationship to Patient:	Phone: ( ) -	

I authorize my insurance benefits 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

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	___	___
Low Blood Pressure	___	___
Normal Blood Pressure	___	___

HEART DISEASE	YES	NO
Heart Attack	___	___
Atherosclerotic Disease	___	___
Myocardial Infarction	___	___
Rheumatic Heart Disease	___	___
Heart Murmur	___	___
Do you have a pacemaker	___	___

MUSCLE CONDITION	YES	NO
Next/Back Strain	___	___
Muscle Tear	___	___
Upper Extremity	___	___
Lower Extremity	___	___
Plantar Fasciitis	___	___

LUNGS	YES	NO
Asthma	___	___
Emphysema	___	___
Shortness of Breath	___	___

JOINT CONDITIONS	YES	NO
Back/Neck Arthritis	___	___
Disc/Sciatica	___	___
Hip/Knee Arthritis	___	___
Ankle Sprain	___	___

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	___	___
Rheumatoid Arthritis	___	___
Multiple Sclerosis	___	___
Epilepsy	___	___
Gout	___	___
Fibromyalgia	___	___
Diabetes	___	___
Hearing Loss	___	___
Poor Eyesight	___	___
Fainting	___	___
Cancer (presently or history of)	___	___

Other: _____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
___ None	___ Sitting	___ Low	___ Smoking	Packs a Day ____
___ 1-2 x Week	___ Standing	___ Medium	___ Alcohol	Drinks a Week ____
___ 3-4 x Week	___ Light Labor	___ High	___ Coffee/Soda	Cups a Week ____
___ 5+ x Week	___ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ___YES ___NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

___YES ___NO If yes list name: _____

List all medications you are currently taking or provide a copy of your list: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ___ YES ___ NO What week?: _____

Have you had any injuries related to work? ___ YES ___ NO If yes list body part and date.: _____

Have you had any Auto Accidents ___ YES ___ NO If yes list body part and date.: _____

Have you had Physical Therapy before? ___ YES ___ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

GENERAL INFORMATION

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 any questions regarding this policy or to request individual alterations to it, please speak with our receptionist. If you feel your privacy has been violated at any time, please ask to speak with our office manager.

Since all insurance companies and policies vary, our policy is that every patient is responsible for knowing their insurance coverage; this includes co-pays, co-insurance, deductible, pre-authorizations, pre-certification, referrals, and limits on visits and reimbursements. Benefits are based on information obtained from the patient's completed initial intake form. SPORT Clinic Physical Therapy is not responsible for misinformation, exclusions, limitations, and non-covered services. **It is the patient's responsibility to verify benefits with their insurance company, understand their plan, and verify that SPORT Clinic Physical Therapy is a participating provider for the physical therapy services provided to you.** We request that your co-pays are paid at the time services are rendered.

Please notify the receptionist immediately if your insurance coverage changes. Some insurance companies have time limits on which we can file, so it is imperative that you provide us with accurate information promptly. As a courtesy to our patients, we will file claims with your insurance for you, including secondary or supplemental. To do this, we need complete and accurate information.

It is the patient's responsibility to obtain a prescription/order for physical therapy. Some insurance companies will not pay for therapy if the patient has not been referred by and have a written order from their treating physician.

Worker's Compensation: Patients need to provide us with Worker's Compensation Insurance carrier name, address, claim number, adjuster's name, contact phone number, and reported date of injury. If your claim is in litigation, special arrangements must be made with our Patient Accounts Manager before treatment.

Medicare: Patients are required by their insurance to have a signed initial order dated 30 days before your initial visit. Medicare Part B pays based on medical necessity after your deductible and 80/20 coverage.

If you are employed and insured by a hospital, you may have a reduction in benefits or not have physical therapy benefits outside their facility.

Patient's/Guardian's Signature: _____ Date: _____

This is a non-exclusive list based on commonly asked questions.