

SPINE & SPORTS MEDICINE

PATIENT INTAKE SHEET

1) Your Name: \_\_\_\_\_

2) Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

3) Sex:  Male  Female    4) Status:  Single  Married  Other    5) If Student:  Full-Time  Part-Time

6) Social Security Number: \_\_\_\_\_ 7) Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

8) How did you hear about us?  1—Referring Physician  2—Yellow Pages  3—Friend  4—Internet  5—Other

9) Employer Name: \_\_\_\_\_ 10) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

11) Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

12) Emergency Contact Name: \_\_\_\_\_ 13) Relationship: \_\_\_\_\_

14) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

15) If Applicable, Attorney Name: \_\_\_\_\_

16) Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ 17) Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

18) If patient is a minor, Guardian / Guarantor Name: \_\_\_\_\_

19) Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

20) If guardian's address is different than the patient, complete field below:

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

21) 1<sup>st</sup> Appointment Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

22) Status:  Active    23) Name of your Therapist: \_\_\_\_\_



Client Initial Self-Assessment Form

The following questions help us design an appropriate therapy plan so that you can get the most out of your PT. Please note that most insurance's cover Physical Therapy only if it is aimed at restoring lost function. In rehabilitation the term function is defined as "any physical activity or action required in the course of like, work, hobbies, or sports". Examples of function include, reaching up into a cupboard, sleeping, walking to the store and swimming.

Please describe the problem or problems you are coming to Physical Therapy for:

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List any activities or function that you are unable to do, or have difficulty with due to your problem:

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Please rate the current disability level of your injured body part from 0-10. Where zero would be totally normal, able to do all activities without difficulty and 10 would totally disabled, unable to do anything.

Rate only your injured body part.

Current functional level (rate from 0-best to 10-worst): \_\_\_\_\_

Please rate your pain levels, over the past 2 weeks, from 0-10. Where zero would be no pain or symptoms of any kind and ten would be the worst possible pain in you can imagine.

Current symptom level (rate from 0 to 10): \_\_\_\_\_

Symptom level of the worst you have had over the past 2 weeks: \_\_\_\_\_

What is the lowest level your symptoms have been in the past 2 weeks: \_\_\_\_\_

Average symptom level over the past 2 weeks: \_\_\_\_\_

What are you hoping to achieve in Physical Therapy?

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Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_



Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

1. Have you ever had any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Metal Implants    |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Drinking Disorder |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Hernia            |
| <input type="checkbox"/> Back Aches                    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Weight Problems   |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Migraines         |
| <input type="checkbox"/> Colitis                       | <input type="checkbox"/> Skin Problems       | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Surgeries         |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Tumor                         | <input type="checkbox"/> Irritability        |  |
| <input type="checkbox"/> Bladder Problems/Incontinence | <input type="checkbox"/> Pregnancy           |  |
| <input type="checkbox"/> Weight Fluctuation            | <input type="checkbox"/> Heart Attack        |  |

2. Surgeries- Please Indicate any surgeries, including date

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Spine and Sports Medicine Institute, Inc.  
General Information, Release of Information, and Policy Overview**

**MEDICARE**

Welcome to our clinic! Our goal is to exceed your expectations of quality patient care and that your treatment will be productive and timely. We are always open to your suggestions for improving our services and encourage you to provide us with your comments. If you enjoy your treatment at SSMI, we hope that you will let your physician know.

We would like to make you aware of several important policies at our clinic, which serve to provide you with a professional, positive, and efficient experience. Please take the time to read this information in its entirety, sign below indicating your agreement, and return this sheet to the receptionist.

As per Medicare policy (“Transmittal 5”), should you wish to continue with your physical therapy **YOU MUST BE SEEN BY YOUR DOCTOR EVERY 30 DAYS TO RENEW YOUR PRESCRIPTION.** If you have any questions relating to this Medicare policy, please call the provider directly at 1800.952.8627.

**Fees for Our Services and Insurance Carriers.** You are solely responsible for the fees associated with your treatment; however, as a service to you, we will bill your insurance carrier provided you have given us all pertinent information including copies of your Medicare and secondary insurance cards. Please be reminded that your insurance policy is a contract between you and your insurance company—we are not a party to that contract. A current prescription is needed in order to collect payment from your insurance carrier and you are advised to review your Medicare Bulletin to ensure you keep your prescription current. If we are unable to collect any balance due from your insurance carrier, you are ultimately responsible for payment of the outstanding balance. We require your payment of co-pay and any unmet deductible at the time of service. After your discharge, any residual credit on your account will be refunded to you, and any outstanding balance not paid by your insurance carrier must be paid by you personally within 15 days. You further agree to pay any additional costs associated with account collection, including agency, attorney and court fees incurred that are permitted by law. Interest on past due balances is assessed at 18% per annum. By signing below you agree to these terms.

**Cancellations and “No Shows”.** If you are unable to keep a scheduled appointment we require 24 hours advance notice. Your consideration allows other patients to be seen by our therapists. If you do not notify us 24 hours in advance you will be charged a \$45 fee for your missed appointment, which is due at the time of your next visit.

**Returned checks.** If your check is returned to us from the bank, your account will be assessed a \$25 processing fee. In the event SSMI does not receive payment, we reserve the right to pursue the California “Bad Check Law” Civil Code B719.

**Assignment of Insurance Benefits.** By signing below, you hereby authorized your insurance carrier or attorney to pay directly to Spine & Sports Medicine Institute, Inc. any benefits allowable for professional services rendered to you.

**Consent to Treatment.** Your therapist will inform you of the treatment prescribed by your physician. Your therapy is provided by SSMI solely at the direction of your physician, and as such SSMI is not liable for any act or omission related to such therapy. You acknowledge that no guarantee or assurance has, or can be made by SSMI as to the expected results of such therapy. By signing below, you consent to have SSMI provide therapy as prescribed by your physician. You may revoke this consent at any time.

**Information Privacy.** As part of the HIPPA regulations we have implemented strict information privacy rules to protect your private information. The SSMI Privacy Policy Statement (attached) explains how we may use your private health information, as well as your rights regarding the use of this information. You may obtain a copy of the SSMI Privacy Policy Statement at any time from the Front Reception Desk. By signing below, you acknowledge that you have received this Statement. You authorize Spine & Sports Medicine Institute, Inc. to release any information it may have concerning your account and treatment, including medical and psychological records, to your insurance carrier(s) and their agents, doctor(s) or attorn(ies), or to any agent of SSMI for purposes related to your care, or for collecting payment for our services. You agree that SSMI may accept photocopies and/or facsimile copies of information requests as valid and legal requests.

SPINE & SPORTS MEDICINE

I have read the information above. I understand and agree to the policies on this sheet. I have received a copy of this “General Information, Release of Information, and Policy Overview” sheet.

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Additional Information for Medicare Patients**

**Welcome to Spine & Sports Medicine Institute.**

One of our Physical Therapists will evaluate your condition and review your doctor’s prescription for therapy. During this first visit your Therapist will design a plan of treatment that includes functional and measurable goals. The therapy plan will be reviewed and signed by your doctor every 30 days. Your doctor will review the progress you have made and will determine if it is medically necessary for you to continue therapy in order to reach your goals within a reasonable length of time.

It is important that you understand you must be seen by your doctor every 30 days in order for him/her to determine if the therapy needs to be continued. **ONLY** the prescription your doctor issues at that office visit, will allow the Therapist to treat you for another 30 days.

Please know that this is a Medicare policy and we are required by law to follow it. If you have any questions regarding the above, you may call Medicare’s beneficiary line at 1-800-952-8627 for help.

**Medicare Billing Procedures**

As a courtesy we will bill your insurance company, provided you have given us all pertinent information including copies of your Medicare and secondary insurance cards. Although we will bill your insurance as a service to you, please be advised that you are responsible for any unpaid deductibles and co-insurance payments as determined on the “Explanation of Benefits” form from your insurance carriers. You will be billed monthly for these charges. We accept cash, check or Visa/Mastercard. If needed, you can set up a monthly payment plan to fit your budget (please see the Account Manager for arrangements or any questions you have regarding this policy).

\_\_\_\_\_  
**Patient’s Signature**

**Date:** \_\_\_\_\_