

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) 1st 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:

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

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?

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

PRIVATE INSURANCE (incl. HPMG)

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.

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 primary 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. If we are unable to collect any balance due from your insurance carrier, you are ultimately responsible for payment of the outstanding balance. At the initiation of your treatment, we will contact your insurance carrier to determine your co-pay amount and any unmet deductible; however, we cannot be responsible for inaccurate information provided by your insurance carrier. We require your payment of co-pay and/or co-insurance and any unmet deductible at the time of service. These payments are based on the estimates provided to us by your insurance carrier but are not guaranteed to fully cover the cost of your treatment. 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 \$20 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.

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: _____

Parent/Guardian’s Signature (for minors): _____ Date: _____