SPORTSPRO
PHYSICAL THERAPY & AQUATIC CENTER

PATIENT REGISTRATION *(Please PRINT Clearly.)*

PATIENTS NAME: FIRST M.I. LAST		BIRTH DATE	AGE	TODAYS DATE SEX M F
HOME ADDRESS: STREET	**APT #**	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO:	MARITAL STATUS	E-MAIL ADDRESS		
HOME PHONE NO:	WORK PHONE NO.	CELL PHONE		
PATIENT'S EMPLOYER		OCCUPATION		
ADDRESS OF EMPLOYER				
SPOUSE/PARENTS NAME (Circle one)	ADDRESS	HOME PHONE NO.		
SPOUSE/PARENT'S EMPLOYER	ADDRESS OF EMPLOYER	WORK PHONE NO.		
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NO.		
REFERRING PHYSICIAN	DATE OF INJURY/ONSET			
PRIMARY CARE PHYSICIAN	HOW WERE YOU REFERRED TO US?			

❑ **WORKERS'COMPENSATION (INJURED ON JOB ONLY) ARE YOU CLAIMING WORKERS' COMPENSATION? YES NO**

DATE OF ACCIDENT	EMPLOYER AT TIME OF ACCIDENT	EMPLOYER NOTIFIED? YES NO	PHONE NO.
INSURANCE CARRIER	ADDRESS	PHONE NO.	
CLAIM/FILE NO.	CLAIMS EXAMINER		

❑ **AUTOMOBILE ACCIDENT**

DATE OF ACCIDENT TIME: AM PM	❑ DRIVER ❑ PASSENGER	ARE YOU COVERED BY PIP (NO FAULT) INSURANCE? YES NO	STATE ACCIDENT OCCURRED IN?
AUTOMOBILE INSURANCE CARRIER		POLICY #	
ADDRESS		PHONE NO.	
INSURANCE AGENTS NAME		PHONE NO.	
ADDRESS		NAME OF INSURED	
ATTORNEY'S NAME/ ADDRESS		PHONE	

Acknowledgement of Receipt *Notice of Privacy Practice:*

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for our practice. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice. If you have any questions about our Notice *of* Privacy Practices, please contact our Privacy Official.

I acknowledge receipt of the *Notice of Privacy Practices*.

Signature: _____ Date_____

If no signature can be obtained, a description of good faith efforts made to obtain the individuals acknowledgement and reason why acknowledgment could not be obtained will be filed in chart. (Initials of staff member) _____

SPORTSPRO PHYSICAL THERAPY & AQUATIC CENTER

Physical Therapy Medical Screening Questionnaire

Date:_____

Name: _____

Gender M / F **Age:** **Height:** **Weight:**

_____

Reason for your visit today? _____

_____

Occupation: _____

List activities/ hobbies that you regularly engage:

_____

_____

Past Surgical History

_____

_____

_____

List all current Medications (or list on back of sheet)

_____

_____

_____

Have you had X-ray, MRI or other studies performed?

☐**Yes** ☐**No** **List**:_____

_____

Are you on a work restriction from your doctor?	**Yes**	**No**	**Are you latex sensitive?**	**Yes**	**No**
Do you take blood thinners?	**Yes**	**No**	**Do you exercise routinely**	**Yes**	**No**
Do you smoke?	**Yes**	**No**	**Do you have a pacemaker?**	**Yes**	**No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐Yes ☐No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you <u>RECENTLY</u> noted any of the following (check all that apply)?

- ❑ Fatigue
- ❑ Malaise
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Weight loss/gain
- ❑ Falls
- ❑ Heartburn/ Indigestion
- ❑ Changes in bowel or bladder function
- ❑ Chest Pain at rest or with exercise
- ❑ Numbness or tingling
- ❑ Muscle weakness
- ❑ Dizziness/lightheadedness
- ❑ Difficulty swallowing
- ❑Cough
- ❑ Change in cognition or mentation
- ❑ Difficulty maintaining balance while walking
- ❑ Loss of feeling between legs
- ❑ Constipation
- ❑ Diarrhea
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Headaches

Have you <u>EVER</u> been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer
- ❑ Heart problems
- ❑ Chest pain/angina
- ❑ Osteoporosis
- ❑ Circulation problems
- ❑ Blood clots
- ❑ Stroke
- ❑ Anemia
- ❑ Bone or joint infection
- ❑ Chemical dependency (i.e., alcoholism)
- ❑ Recent Infection
- ❑ Endometriosis
- ❑ Depression
- ❑ Lung problems
- ❑ Tuberculosis
- ❑ High blood pressure
- ❑ Rheumatoid arthritis
- ❑ Other arthritic conditions
- ❑ Eye problem/infection
- ❑ Kidney problem/infection
- ❑ Sexually transmitted disease
- ❑ Pelvic inflammatory disease
- ❑ AIDS/ HIV
- ❑ Other:_____
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Multiple sclerosis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Ulcers
- ❑Bladder infection
- ❑ Liver problems
- ❑ Hepatitis
- ❑ Pneumonia
- ❑Immune Suppression Disease
- ❑ Hormonal Imbalance

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑Cancer ❑ Diabetes ❑ Tuberculosis ❑ Heart problems ❑ Stroke ❑ Rheumatoid Disease
❑ Thyroid problems ❑ High blood pressure ❑ Depression ❑ Blood clots

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During the past month have you been feeling down, depressed or hopeless? ☐**YES** ☐**NO**

During the past month have you been bothered by having little interest or pleasure in doing things? ☐**YES** ☐**NO**

Is this something with which you would like help? ☐**YES** ☐**YES, BUT NOT TODAY** ☐**NO**

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Physical Therapy Medical Screening Questionnaire

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐**YES** ☐**NO**

Current Symptoms

Where are you currently having symptoms? _____

What date (approximately) did your present pain start?_____

How did it start (gradually, suddenly, injury)?_____

My symptoms are currently: ☐**Getting better** ☐**About the same** ☐**Getting worse**

Have you ever had this problem before: ☐**YES** ☐**NO**

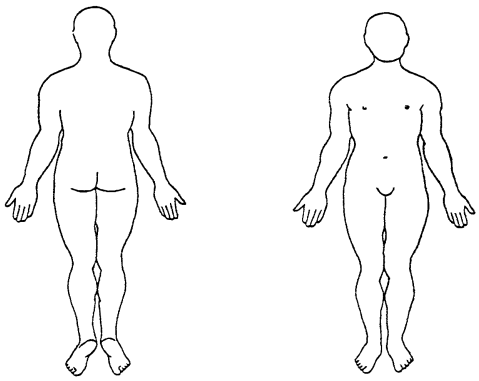
Have you received any treatment for this problem? ☐**YES** ☐**NO**

If so, how was the problem treated?_____

How long did it take for you to feel better?_____

Does taking a deep breath or twisting your back aggravate your symptoms? ❑ **YES** ❑ **NO**

Body Chart: Please mark the areas where you feel pain on the chart below



Circle your pain level TODAY

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

Circle the MOST amount of pain you have experienced over the last 24 hrs

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

Circle the LEAST amount of pain you have experienced over the last 24 hrs

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

LEGEND

X Sharp, = Ache, + Pins & Needles, O Other

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

What makes your symptoms worse?_____

What makes your symptoms better?_____

Describe your sleeping patterns?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

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Rate your overall **FUNCTION** (Cannot do anything) 0 1 2 3 4 5 6 7 8 9 10 (Able to do everything)

Is there anything that you would like your Therapist to know about you or your condition?

_____

_____

_____

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PATIENT FINANCIAL RESPONSIBILITY/WAIVER

Thank you for selecting Sports Pro Physical Therapy to provide your physical therapy needs. The service you have elected to receive implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will attempt to verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for your payment of your bill. **PLEASE NOTE: VERIFYING COVERAGE DOESN'T GARANTEE PAYMENT.**

By signing below, you agree to the following terms:

1) I understand that by authorizing Sport Pro Physical Therapy, through its appropriate personnel, to perform physical therapy treatments and services, I agree to provide the necessary and appropriate information required to bill the services provided.

2) I understand that deductibles, co-payments, or co-insurance amounts as determined by my contract with my insurance carrier are due **AT THE TIME OF SERVICE**. We accept cash, check credit cards (Master and Visa) or money orders. Returned checks will be assessed an additional $25.00 per item, which CANNOT be billed to my insurance carrier.

3) I understand that Sports Pro Physical Therapy has a 24-hour prior notice cancellation policy. A fee of $50.00 will charged if I fail to cancel my appointment 24 hours prior to my scheduled appointment time. This fee CANNOT be billed to my insurance carrier. **X_____Initials**

4) I further understand that I am financially responsible for all charges of covered and/or non-covered services, services determined to be not medically necessary by my insurance carrier, any services denied by my insurance carrier, or my election to continue therapy beyond my insurance coverage.

5) Should timely payments on my account not be made, I understand the Sports Pro Physical Therapy may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses (including collection fee of 33.33% and attorney fees) incurred by such action shall become and additional liability for which I assume responsibility.

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____

12200 Annapolis Road, Suite 119 Glenn Dale, MD 20769 Ph.301.805.5006
9440 Pennsylvania Avenue, Suite 215 Upper Marlboro, MD 20772 Ph. 301.599.8899
930 E. Swan Creek Road, Ft Washington, MD 20744 Ph. 301-292-9400

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AUTHORIZATION AND ASSIGNMENT

I certify to the best of my knowledge that the information I have given is correct.

COMMERCIAL INSURANCE AUTHORIZATION AND ASSIGNMENT

I herby authorize the release of any medical or other information necessary to treat my condition or process my claims to Medicare and/ or any other insurance company. I also authorize payment of medical benefits from Medicare and/ or any other insurance company to be made directly to Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC for services provided. This assignment will remain in effect until I revoke it in writing. I understand that information concerning my condition is confidential and will only be released upon my written consent. I, the undersigned, give Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC the consent to evaluate and treat me.

Signature:_____ **Date** _____

MEDICARE AUTHORIZATION AND ASSIGNMENT

(For patients with Medicare Primary or Secondary Insurance)

I request that payment of authorized Medicare benefits be made on my behalf to Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC for any and all medically necessary services provided me. I Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC to release to the Centers of Medicare and Medicaid Services and it agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature request that payment be made directly to Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC and that it authorizes the release of medical information necessary to treat my condition or pay claims that I have incurred. If "other health insurance" is indicated in Item 9 of the HCFA 1500 form, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases Sports Pro Physical Therapy, LLC or Sports Pro Physical Therapy South, LLC aggress to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I here by authorize the release of all information necessary to secure the payment of said benefits. I have read the above policy and understand and accept them as stated.

Signature:_____ **Date** _____

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OFFICE POLICIES

AUTOMOBILE ACCIDENTS: If you were injured in an automobile accident, we will submit your bill to your automobile insurance for payment through your Personal Injury Protection (PIP) coverage. We do not accept 3rd party insurance claims. If you elect **not** to use your PIP insurance, **payment is expected at time of service**. It is our policy to obtain your health insurance information and obtain authorization, in the event that your PIP has been exhausted. If you do not have health insurance, or do not wish to use it, **any and all unpaid balances will be the responsibility of the patient**. If you have an attorney representing you, we will supply him/her with a copy of your records at their request once we have received written notice, your consent and payment for medical record copying charges according to the Health-General Article§ 4-304 (c) (3).

WORKMAN'S COMPENSATION: If you were injured on the job we will submit you bill directly to the workman's compensation carrier. It is our policy to obtain your health insurance information in the event that your claim with the workman's compensation carrier is denied. **If you do not have health insurance, or do not wish to use it you will be directly responsible for all claims and payment will be expected at time of service.**

Insurance Companies we do not participate with:

We will submit your claim directly to your insurance company for you. Ultimately, patients are responsible for the total charges minus any insurance payments and payment is expected at the time of service. **Any unpaid balances remain the responsibility of the patient.**

Insurance Companies that we participate with:

We will submit your claim for you, however this does not relieve you of your responsibility to pay your bill. Co-payments are due at the time of service. Sports Pro Physical Therapy, LLC does not balance bill patients and accepts contracted insurance company payment as full payment. However, this does not include the patients' responsibility their for co-payment, co-insurance or deductibles. Any and all unpaid balances are the responsibility of the patient.

MISSED APPOINTMENTS: There will be **a $50 charge for all appointments not cancelled 24 hours** in advance. Your insurance company will not pay for this charge; therefore, the patient is responsible for this payment, which is expected, and due at the time of the next scheduled visit.

RETURNED CHECKS: There will be a **$25 charge for all returned/cancelled checks**. You may be request to pay by cash or money order after the first returned check.

Failure, on the part of the patient to pay the balance due on an account, will result in that account being turned over for collections. Filing insurance claims is a service provided without charge and in no way relieves the patient of financial responsibility of their bill. Also, please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment.

I understand that I am financially responsible for all charges whether or not they are covered/ paid by my insurance. I hereby authorize the release of all information necessary to secure the payment of said benefits. I have read the above policies, understand, and accept them as stated.

_____ _____

Signature **Date**