

ELITE SPORTS MEDICINE & PHYSICAL THERAPY

PATIENT REGISTRATION

Patient Information

Your Name:				Today's Date:	
Date of Birth:	Age:	Height:	Weight:	Social Security #:	

Female Male
 Single Married Divorced Widowed

Home Address:	Home Phone:	Messages okay? Y / N
City, State, Zip:	Cell Phone:	Messages okay? Y / N
Employer:	Work Phone:	Messages okay? Y / N
Address:	Email Address:	
City, State, Zip:	Occupation:	Full Duty/ Light Duty/ Off Work

Emergency Contact:	Phone:	Relationship to patient
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Referring Physician:	May we email your doctor about your case? Y / N	Phone:	Fax:
Last Dr. Appt.:	Next Dr. Appt.:		
Primary Physician: (If different than above)	Phone:	Fax:	

Spouse or Responsible Party Information (if different from above)

Name:	Social Security #:
Home Address:	DOB:
City, State, Zip:	Home Phone:
Employer:	Cell Phone:
Address:	Work Phone:
City, State, Zip:	Occupation:

How did you hear about ELITE? (check all that apply)

Physician Insurance Co. Website Word of Mouth Employer Drove By Other:

Past Medical History

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

1) Do you now have or have you ever been diagnosed with any of the following?

Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Condition <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness/ Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeping Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clot/ Emboli <input type="checkbox"/> Yes <input type="checkbox"/> No	Energy Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke / TIA <input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/ Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/ Tingling <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss/ Gain <input type="checkbox"/> Yes <input type="checkbox"/> No
Do You Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, Copy included in chart? <input type="checkbox"/> Yes <input type="checkbox"/> No)	Psychological Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No

2) Please list any allergies: _____

3) Please list all medications WITH DOSAGES you are currently taking (prescription or non-prescription): _____ **VERIFIED BY PT:**

4) At the present time, would you describe your overall health as: (circle one) **Excellent, Good, Average, Below Average, Poor**

5) At the present time, whom do you live with? (circle all that apply) **Alone, Spouse/ Significant Other, Child(ren), Relatives, Group Setting**

6) Do you have a safe home environment? (circle one) **Yes / No If no, please discuss this with your therapist.**

ELITE SPORTS MEDICINE & PHYSICAL THERAPY

Past Orthopedic Medical History

Please indicate any **PREVIOUS** orthopedic injuries or surgeries.

Neck Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Shoulder Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Elbow Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Hand Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Back Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Hip Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Knee Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Ankle/ Foot Injury/ Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____
Have you had any falls in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Please Describe: _____

VERIFIED HOME FALL HAZARDS:

Tell Us About the Condition or Injury Which We Are Seeing You For

1) When did your injury first occur? Or When did you first start to notice your symptoms? _____

2) Where are your symptoms located? _____

3) What is your condition related to – How did the injury occur? (please check one and explain)

<input type="checkbox"/>	Work Comp			
<input type="checkbox"/>	Auto Accident	Date of accident	State of accident	
<input type="checkbox"/>	Other			

4) Is an attorney involved with this condition/ injury? Yes No If yes, please provide name and phone number: _____

5) Which, if any, Medical Professionals have you seen for this injury? (check all that apply)

<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>	Orthopedist	<input type="checkbox"/>	ER Physician	<input type="checkbox"/>	Neurologist	<input type="checkbox"/>	Podiatrist
<input type="checkbox"/>	Physical Therapist	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	Massage Therapist	<input type="checkbox"/>	Chiropractor	<input type="checkbox"/>	Other:

6) Which, if any, Medical Tests have you had for this injury? (check all that apply)

<input type="checkbox"/>	X-Ray	<input type="checkbox"/>	MRI	<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	Arthrogram
<input type="checkbox"/>	Myelogram	<input type="checkbox"/>	EMG/ Nerve Conduction	<input type="checkbox"/>	Blood Work	<input type="checkbox"/>	Other:

7) What is your main problem related to this condition? _____

8) Have you had any surgery for your injury/condition? Yes No If yes, what kind and when? _____

9) Have you received any injections for your injury/condition? Yes No If yes, when? _____ Did it help? Yes No

10) How often do you experience your current symptoms? Always Frequently Occasionally Seldom

11) Using this scale (0 = No Pain, 10 = Emergency Type Pain)

I currently rate my pain at a: _____
 My Highest pain in the last 30 days has been: _____
 My Lowest pain in the last 30 days has been: _____

12) Using this scale (0 = No Function, 10 = Ability to Perform Normal Daily Activities)

I currently rate my functional level at a: _____
 My Highest functional level in the last 30 days has been: _____
 My Lowest functional level in the last 30 days has been: _____

13) Place an (X) on the line at the point at which accurately describes the intensity of your pain now

Normal/ No Pain ----- Emergency/ Extreme Pain

14) What do you hope to accomplish with therapy? _____

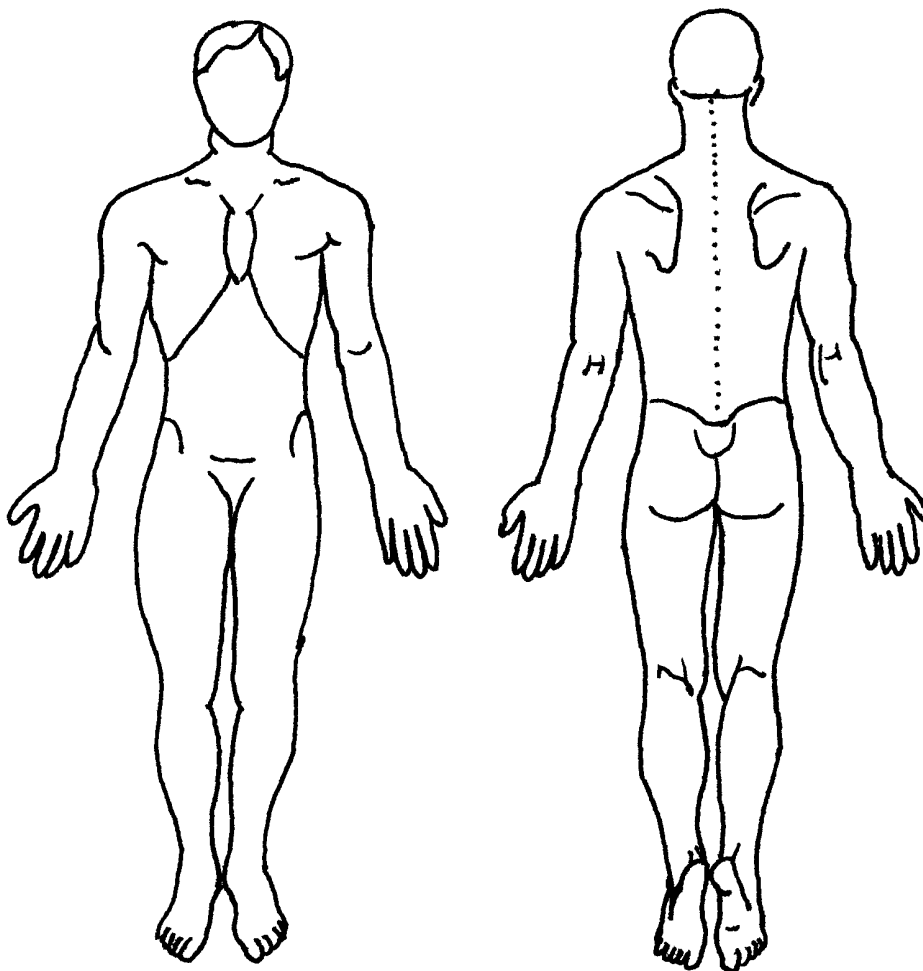
Name: _____ Date of Birth: _____ Date: _____

MEDICARE BENEFICIARIES ONLY

- 1) Are you currently or in the last 6 months receiving Home Health? Yes No
If yes, have you seen: nursing, respiratory therapy, home health aide: name _____ other: _____
- 2) Are you covered by Black Lung Disease? Yes No
- 3) Are you covered by End Stage Renal Disease (on dialysis, etc.)? Yes No
- 4) Are you covered by large group insurance (directly or by a spouse)? Yes No If yes, Group Name/Number: _____
- 5) Is this condition due to an accident? Yes No
If yes: home, auto, other: _____
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ALL PATIENTS - PAIN DRAWING

Name: _____ Date of Birth: _____ Date: _____



Please mark your pain or other symptoms on the above diagram.

ELITE SPORTS MEDICINE & PHYSICAL THERAPY

PLEASE INITIAL EACH SECTION

AUTHORIZATION FOR CARE/ INFORMED CONSENT

I/we hereby authorize to receive care at Elite Sports Medicine & Physical Therapy, LC. I/we understand that receiving physical therapy or strength and conditioning may involve stress of musculoskeletal tissue that may cause soreness (like one might feel for a few days after starting a workout program such as running or lifting weights.) Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of your current condition is also possible.

Furthermore, I/we understand that the provider may need to perform mobilization technique, manipulation technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, taping, bracing, orthotic fitting, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

There are several benefits associated with testing. These include: confirmation of the present medical condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. These may include: increased flexibility and strength, decreased pain, improved cardiovascular endurance and coordination, and better circulation; all combining to improve function in activities of daily living.

Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program with your signature below.

X INITIAL: _____

ATTENDANCE POLICY

It is our pleasure to provide rehabilitation services at Elite Sports Medicine & Physical Therapy, LC. You have been referred here for treatment, and consistent attendance is a requirement both from a therapeutic standpoint and compliance standpoint. In the event you are unable to keep a scheduled appointment or participate in your program, you are to notify us prior to the scheduled appointment or program time.

In instances of absence from rehabilitation, if applicable, our clinic may inform your insurance carrier, employer, and referring physician or rehabilitation nurse. If two consecutive absences occur without notification from you for the reason for absence, rehabilitation will be discontinued secondary to non-compliance in respect to attendance. Please understand that increased symptoms are not considered valid reasons for missing rehabilitation. If your symptoms increase, we especially need to have you present to address these symptoms and modify your program as indicated.

Advance notice of 24 hours is requested if you are not able to keep an appointment. If you no show or cancel an appointment in less than 24 hours, you may be charged a \$50 fee for the missed appointment.

X INITIAL: _____

ASSIGNMENT & RELEASE (For All Patients)

I, the undersigned, assign directly to Elite Sports Medicine & Physical Therapy, LC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that if I have a co-pay it will be due at the time of service. Medicare Authorization: I request that payment of authorized Medicare or Medigap benefits be made on my behalf to Elite Sports Medicine & Physical Therapy, LC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" or "Medigap" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. **NOTE:** Medicare has placed a \$1860 cap on outpatient rehabilitation coverage for the year. If you have had prior physical therapy and/ or speech therapy visits in 2010, please inform us. I certify that the information provided to Elite PT for payment under the Social Security Act (Medicare) including but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

X INITIAL: _____

ELITE SPORTS MEDICINE & PHYSICAL THERAPY

PAYMENT POLICY

Elite PT will bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Elite PT. It is ultimately your responsibility to see that your physical therapy bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Elite PT within 5 weeks, it will be your responsibility to contact it. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 30 days. IF PAYMENT IS NOT RECEIVED WITHIN THIS 30-DAY PERIOD, A FINANCE CHARGE WILL BE ASSESSED PER MONTH. IN THE EVENT A CHECK IS RETURNED FOR ANY REASON, A \$25.00 CHARGE WILL BE MADE TO YOUR ACCOUNT. YOU AGREE TO PAY ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, INCURRED IN THE COLLECTION OF PAST DUE ACCOUNTS. Amounts turned over for collection will be subject to 25% collection fee. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of medical necessity. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. The parents (or guardians) accompanying a minor are responsible for payment of the minor's treatment.

X INITIAL: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered the Elite Sports Medicine & Physical Therapy, LC notice of Privacy Practices.

By signing below, I acknowledge that I have read and agree with Elite Physical Therapy's Authorization of Care/ Informed Consent, Attendance Policy, Assignment and Release, Medicare Authorization (if applicable), Payment Policy, and Acknowledgement of Privacy Practices

Patient Name: _____ **Date of Birth:** _____

Signature: **X** _____ **Today's Date:** _____

If Patient is a minor, to be signed by Parent or Guardian

Printed Name of Parent or Guardian: _____

Are you interested in a consultation on how to become more active and fit?

Please check here if you would like someone from Elite's Wellness Department to contact you.

_____ **Yes, please have Elite's Wellness Department contact me. I understand that this program is not covered by insurance and that different packages are available. (No obligation necessary)**