

New Patient Form

Therasport

Date _____

Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ include area code Cell Phone _____ include area code

Sex _____ Birth Date _____ mm/dd/yyyy Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____

Patient's Employer _____ Occupation _____ Work Phone _____ include area code

Spouse's Name _____
Last Name First Name Middle Name Name goes by

Spouse's Employer _____ Occupation _____ Work Phone _____ include area code

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____ include area code

Referring Physician

Referring Physician _____

Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Therasport to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Therasport or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

TheraSport, Inc.
MEDICAL HISTORY FORM

By answering the following question, the therapist will be able to provide a safe and effective treatment plan.

Referring Physician: _____ Primary Care Physician: _____

Problems to be treated: _____

Have you ever had treatment for this problem before: YES / NO

If YES, please list date and type of surgery: _____

List any other major illness or surgery that has occurred in the past year:

Are you currently taking any medications? YES / NO

If YES, please list all medications: _____

Do you now have/or have you at any time had any of the following?

High Blood Pressure	Y/N	Headaches	Y/N	Kidney Problems	Y/N
Heart Disease	Y/N	Allergies	Y/N	Nervous Disorders	Y/N
Heart Attack	Y/N	Hernia	Y/N	Hearing Problems	Y/N
Pacemaker	Y/N	Seizures	Y/N	Balance Problems	Y/N
Diabetes	Y/N	Metal Implant	Y/N	Vision Problems	Y/N
Sensitive to Heat/Ice	Y/N	Dizzy Spells	Y/N	Cancer	Y/N

If YES on any of the above, please explain and give approximate dates: _____

Do you need assistance with any of the following?

Transportation	Y/N	Domestic Chores	Y/N	Meals	Y/N
Shopping/Errands	Y/N	Personal Care	Y/N	Other:	_____

Has your illness/disability caused any of the following?

Financial Problems	Y/N	Family Problems	Y/N
Emotional Problems	Y/N	Other:	_____

Have you ever had Physical/Occupational Therapy before? YES / NO

Are you pregnant? YES / NO

THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature and Date

Welcome to TheraSport!!!

Please take a minute to review our payment policies. The office administrator will be happy to answer any questions you may have.

Payment Policies

All charges that you incur at our office are your responsibility. You may pay for your charges at each visit or choose to use our insurance filing service. There is not extra charge to use this service, however you must agree to the following terms.

On your first visit, you will be required to pay any unmet deductible and co-insurance. We request that you pay your co-insurance at each visit.

The billing department will file all insurance claims for you. Your insurance company must allow you to have reimbursement payments sent directly to us. If your insurance does not allow this, we require that you pay for all treatment at the time of visit.

Financial Responsibility

We will bill your insurance company daily and use our best efforts to obtain payment. However, any charges that remain unpaid for 60 days after the billing become your responsibility to pay. We will send you a statement monthly which will notify you of any charges that your insurance company declines to pay. It will also inform you of payments made by your insurance company and you and of your present balance. If your accident results in a litigation process, payment must be made on a monthly basis until settlement is reached. After settlement is concluded, payment is due in full.

Appointment Cancellations

To prevent our patients from waiting for treatment, we do not overbook appointment times. Extra staff is brought in to service our patients when necessary. Please give us 24 hours when canceling appointments. We often have a waiting list of patients who may need a specific time of day for their appointments.

Please initial one:

_____ I would like to use the insurance filing service of this clinic and agree to the terms above.

_____ I would prefer to file my own insurance claims and will pay my bill in full at each visit.

I have read and understand the payment policies of TheraSport, Inc.

Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of ~~THE CASPOT~~. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

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TheraSport, Inc.

Patient Name: _____

HIPAA Acknowledgement/Consent

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for TheraSport, Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations.

Signature of Pt. or authorized Represent.

Date

If representative, print name and relationship:

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