Patient Registration Form

Please Print

Today's Date:_____ Patient's Last Name:_____First Name:_____

Patient's Date of Birth:_____ Social Security #:_____ Gender: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____Is this a cell? (Yes No) E-Mail:_____

How did you hear about us? _____

Referring Physician:_____

Emergency Contact:_____Relationship/Phone:_____

For Minors:

Parent/Guardian:_____Parent/Guardian Social #:_____

Relationship to Patient:_____Parent/Guardian Birth Date:_____

Insurance Information (Please give insurance card to the front office)

Primary Insurance

Insurance Co Name:_____Policy Holder:_____

Policy Holder Birth Date:_____ Policy Holder Social Security #:_____

Employer:_____ Employer Phone #:_____

Employer Address:_____

Group #:_____ Policy #:_____

Secondary Insurance (if applicable)

Insurance Co Name:_____Policy Holder:_____

Policy Holder Birth Date:_____ Policy Holder Social Security #:_____

Group #:_____ Policy #:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC. I understand that I am financially responsible for any balance. I also authorize SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____

Patient Consent for Assessment and Treatment

Physical Therapy treatment techniques may include, but are not limited to: manual techniques, spinal manipulation, electrotherapeutic modalities, dry needling, cupping, and therapeutic exercises. These may be recommended during your program. It is the policy of SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC to ensure that the benefits, side effects, and potential complications of each chosen modality above are explained to you by your therapist. Throughout the program, should you have concerns, or questions about any recommended treatment, you must inform the therapist immediately so rationale for treatment and/or adjustments can be made. It is your responsibility to participate in all aspects of the program as it is imperative to its success.

I understand and agree with the above policy. I give consent for SPARK PERFORMANCE AND PHYSIOTHERAPY to provide me with an assessment and also treatment for services. I understand that I can withdraw my consent at any time.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian (if patient is a minor) Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA/Privacy)
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Notice of Privacy practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health information
We will use and disclose your health information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limit operational activities such as quality assessment, licensing, accreditation, and training of students or staff.

Uses and Disclosures Based on your authorization
Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written consent.

Uses and Disclosures not requiring your Authorization
In the following circumstances, we may disclose your health information without your written authorization:
- To family members to close friends who are involved in your healthcare
- For purposes of public health and safety
- To Government agencies for purposes of their audits, investigations, and other oversight activities:
- To Government authorities to prevent child abuse or domestic violence
- To the FDA to report product deficits or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, subpoenas, and as otherwise required by law

Patient rights
As our patient, you have the following rights:
- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate to you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have a question, concern, or complaint regarding our privacy practice, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

HIPAA Contact: Steven Alexander PT, DPT, Cert DN

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. I authorize SPARK PERFORMANCE AND PHYSIOTHERAPY to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

_____

Signature of Patient Date

_____

Signature of Parent/Guardian (if patient is a minor) Date

FINANCIAL POLICY

Insurance Disclaimer:

As a service to our patients, SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC will verify benefits with your insurance company and submit charges for medical services. A quote of benefits and/or authorizations does NOT guarantee payment or eligibility. Payment of coverage from your insurance are subject to all terms, conditions, limitations, and exclusions of your contract at time of service. However, the patient is primarily responsible for paying any and all deductible, coinsurance, and copay amounts. ALL COPAYS/CO-INSURANCES/DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. A $35 service fee will be applied to all returned checks. Please remember that your insurance is a contract between you and the insurance carrier, not with SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC.

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not "reasonable and necessary", or that a particular service is not covered under the plan, your insurer will deny payment for that service. Our office will make every effort to work with your insurance company to justify our services as medically necessary.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Intake and Verification:

The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance.

Overdue Accounts:

Account balances should be paid within 30 days of the account statement. A late fee of $15.00 will be assessed after for each month. If a patient account is 60 days overdue, the patient will be notified in writing that the patient has 15 days to pay in full. A second letter will be sent within 15 days if the balance remains unpaid. Be aware that if a balance remains unpaid we may refer the patient's account to a collection agency. Any collection agency fees or costs will be added to the outstanding balance and the patient will be responsible for the collection agency fees.

Medical Records:

There will be a fee of $20.00 for up to 50 pages, and anything over 50 pages is $40.00 to copy records. We will provide records to your physician, with a signed consent, at no charge.

_____ _____

Patient/Guardian Signature Date

CANCELLATION POLICY

Thank you for choosing SPARK PERFORMANCE AND PHYSIOTHERAPY, LLC for your physical therapy needs!

We truly value you as a patient of ours and will do everything in our powers to get you back to your daily activities in the quickest manner.

Here at SPARK PERFORMANCE AND PHYSIOTHERPY, LLC, we dedicate your appointment time to be spent with a licensed therapist and not technicians/aides who are far less qualified and require no formal education. This scheduled time with the therapist only allows the therapist to continually monitor, assess, and progress/digress as needed. This leads to the return to highest level of function in the quickest amount of time. We feel it is crucial to be spending your appointment times with a licensed therapist, so we schedule your appointments that way. Please be courteous to this and stick to your scheduled appointments. There will be a $50 fee for cancellations that occur outside of a 24-hour window prior to your scheduled appointment. If you do not show up or call to cancel an appointment, you will be charged the $50 and all remaining appointments will be removed from the schedule. You may return to the schedule after a discussion with the treating therapist. We understand that emergencies come up that prevent you from attending a therapy appointment; those will be dealt with on a case-by-case basis.

In addition to the cancellation policy, there is a 15-minute tardy policy. If you are more than 15 minutes late to your appointment, the appointment may be cancelled for that day. This is to be courteous of your time and the therapists' time. We do not want your tardiness to compromise your care or the care of fellow patients.

The cancellation policy is set in place so that we can continue to provide the highest quality of care to our patients. We want all of our patients to be able to spend their appointments with a licensed therapist. Please be courteous and respectful and inform the clinic as soon as you can if you must miss an appointment.

I have read, understand, and agree to the above Cancellation Policy

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

NEW PATIENT HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Date: _____
Where are you currently having symptoms? _____
Describe your pain: _____
When did your pain start? _____ Is your pain getting: *Better* *Worse* *No Different* (circle one)
What caused your pain to start? _____
Have you had this pain before? (describe) _____
_____
List of medications: _____

CURRENTLY, or RECENTLY I am experiencing: (mark those that apply)					
Fever/Sweats		Difficulty swallowing		Confusion	
Fatigue		Dizziness		Fainting	
Nausea/Vomiting		Increased pain at night		Changes in appetite	
Headaches		Weakness		Numbness/tingling	
Depression		Changes in bowel/bladder function		Unexplained weight loss	
Poor balance/falls		Shortness of breath			

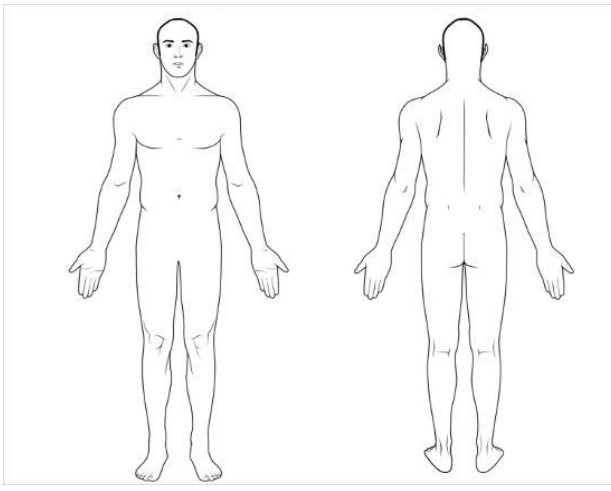
PAST MEDICAL HISTORY

___ Cancer ___ Diabetes ___ Stroke ___ Epilepsy
___Fibromyalgia ___ High blood pressure ___ Heart Condition ___ Pacemaker
___ Asthma ___ Lung Disease ___ Osteoarthritis ___ Hepatitis
___ Rheumatoid Arthritis ___ Blood Clots/Disorders ___ Multiple Sclerosis ___ Parkinson's
___ Infectious Disease (please describe) _____
___ Allergies (please describe) _____

Body Chart (Please mark the areas where you feel pain on the body chart)

-On a scale of 0-10 (10=emergency room) rate your current pain:

0 1 2 3 4 5 6 7 8 9 10



-List 3 activities you can't, or have trouble doing now, due to the pain:

1._____
2. _____
3. _____

I hereby acknowledge that the information I provided on the Intake Form and the Patient Data Sheet is correct.

_____ _____

Signature **Date**