

# PATIENT INFORMATION FORM

---

## Patient Information

Appt. Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: **M S D W** Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

---

## Referral Information

Prescription Date: \_\_\_\_\_ Frequency and Duration: \_\_\_\_\_ Area of Treatment: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Upin/NPI: \_\_\_\_\_ Therapist: \_\_\_\_\_

---

## Insured Information (insurance policy holder information)

Insured Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Address

---

## Guarantor Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

---

## Insurance Information

Primary Insurance: \_\_\_\_\_ Insured ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

**Worker's Comp:** Date of Injury: \_\_\_\_\_ Date of Loss: \_\_\_\_\_ W/C Claim #: \_\_\_\_\_

**Auto:** Date of Injury: \_\_\_\_\_ State of Accident: \_\_\_\_\_

Insurance Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer Contact (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**RICHARDSON SPINE AND SPORTS THERAPY  
CONSENT FOR CARE & TREATMENT**

I, the undersigned, do hereby agree and give my consent for Richardson Spine and Sports Therapy to furnish medical care and treatment to considered necessary and proper in diagnosing or treating his/her physical and mental condition.

**Patient/Guardian /Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers' to Richardson Spine and Sports Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

**Patient/Guardian/Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_

## 2009 Financial Policy

Richardson Spine & Sports Therapy, LLC will bill your insurance carrier as a courtesy to you \_\_\_\_\_. You are responsible for the entire bill when services are rendered. Payments of your estimated share must be made on the date services are provided. Should your insurance carrier fail to remit payment within 60 days; the balance of your account will be due. In the event that your insurance company requests a refund of payments made, you will be responsible for the refunded amount to your insurance carrier. If any payments are made directly to you for services billed by Richardson Spine & Sports Therapy, LLC, you are responsible for reimbursement to Richardson Spine & Sports Therapy, LLC. within three business days.

### **New Policy - Cancellations of Appointments/No Show**

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.

- If you any reason you need to cancel an appointment, please notify the office as soon as possible.
- On your second no-show/cancellation occurrence, there will be a \$35.00 charge to your account, payable by the patient.
- This fee will not be submitted to your insurance carrier.
- The charge for the no-show/early cancellation is a direct reflection of a missed business opportunity.

**This policy applies to ALL patients without discrimination of health coverage.**

**Estimated** insurance benefits given by your health insurance policy:

I UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ADHERE TO ALL CONDITIONS WITHIN.

\_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Representative/Witness

\_\_\_\_\_  
Date

**Patient Health Information**

Name: \_\_\_\_\_

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal

- Osteoarthritis
- Rheumatoid arthritis
- Polymyalgia
- Lupus/SLE
- Fibromyalgia
- Chronic Fatigue
- Osteoporosis
- Headaches/Migraines
- Bulging Disks
- Leg Cramps
- Jaw pain/TMJ
- History of Falls
- Use cane, walker or crutches
- Other: \_\_\_\_\_

Circulation/Respiration

- Heart Condition
- Heart Attack
- Heart Arrhythmias
- Pace Maker
- High Cholesterol
- Blood Clots/Phlebitis
- Anemia
- Other: \_\_\_\_\_

Digestion

- Diabetes
- Kidney Problem
- Irritable bowel
- Bladder problem
- Liver problem
- Hernia
- Other: \_\_\_\_\_

Nervous System

- Stroke/TIA
- Parkinson's
- Multiple Sclerosis
- Epilepsy/Seizures
- Concussion/Brain injury
- Numbness or tingling
- Other: \_\_\_\_\_

Infectious Diseases

- TB
- Hepatitis
- Polio
- Other: \_\_\_\_\_

Skin

- Skin allergies/rashes
- Eczema/psoriasis
- Infectious skin diseases
- Shingles
- Other: \_\_\_\_\_

Please list any prior accidents, broken bones, or surgeries with approximate dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. Have you had surgery for this injury? Yes \_\_\_ No \_\_\_ Surgery Date(s): \_\_\_\_\_

2. When did pain begin? (Date of Injury) \_\_\_\_\_

3. Have you had any Medical or Rehabilitative services for this injury/episode? Yes \_\_\_ No \_\_\_

4. Have you had **ANY** physical therapy this calendar year? Yes \_\_\_ No \_\_\_ If so, please identify the area(s) of therapy you have been treated for **THIS** year. \_\_\_\_\_

5. Are you currently taking any prescription or non-prescription medications? If so please list them: \_\_\_\_\_

6. Do you Smoke? Yes \_\_\_ No \_\_\_                      7. Are you pregnant? Yes \_\_\_ No \_\_\_

8. List any other information that would assist us in your care: \_\_\_\_\_

9. Are you aware of what your diagnosis is? \_\_\_\_\_

10. Based upon your awareness, what are your expectations/goals while in Therapy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed contraindications with \_\_\_\_\_ prior to initiating evaluation and treatment. The following contraindications were identified:

I have reviewed with \_\_\_\_\_ their rehabilitation potential prior to initiating treatment.

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_