

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** _____

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: _____

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

RICHARDSON SPINE & SPORTS THERAPY

PATIENT BILLING AGREEMENT

Dear Patient,

Presently, Richardson Spine & Sports Therapy is not a participating provider with various insurance carriers. We do have every intention of contracting with these carriers, but because we are a brand new facility, this could not be completed by the time we opened the facility.

It is sometimes the policy of the insurance carriers NOT to pay the providers who are not participating with them, but to pay the patients instead. This means that after your insurance carrier has processed your claim(s) for the facility charges, all payments and their corresponding explanations of benefits will go to you (the patient) and not to Richardson Spine & Sports Therapy.

Please note that this only applies to claims for Richardson Spine & Sports Therapy, not your other healthcare providers such as your physician, lab charges, or radiology charges.

This letter is to serve as an agreement noting that when you do receive the check and explanation of benefits from your insurance carrier for services rendered to you by Richardson Spine & Sports Therapy, you will immediately forward them to our office. Again, please remember that any funds you receive belong to Richardson Spine & Sports Therapy for services you received.

I _____ agree that when I receive any checks, Explanation of Benefits, or other correspondence relating to services rendered to me at Richardson Spine & Sports Therapy from my insurance company, I will immediately forward them to the business office.

I understand that I will be held entirely accountable for any outstanding or unpaid balances on my account until I have turned over any and all checks I have received from my insurance carrier to Richardson Spine & Sports Therapy.

Patient Signature _____ Date _____

Witness _____ Date _____