



D&D Sports Med

___ Denton ___ Sanger ___ Aubrey

Patient Information Medicare Patient

D&D SPORTS MED

DENTON • SANGER • AUBREY

Patient Registration Information

Name: (First) (MI) (Last)			Social Security #:		
Date of Birth:			Address:		
Home Phone:			City:	State:	Zip:
Cell Phone:			Email Address:		
Sex: Male Female	Marital Status: Single Married Other: _____				

Insured Party/Responsible Party Information

Relationship to Patient:			Social Security #:		
Name: (First) (MI) (Last)			Date of Birth:		
Address:			City:	State:	Zip:
Home Phone:			Work Phone:		
Sex: Male Female	Marital Status: Single Married Other: _____				

Patient's Employer Information

Insured's Employer Information

Employer:			Employer:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Injury Information

Date of Injury:	Description of Injury/How did injury occur?
Injury occurred: Work Auto accident	
Other: _____	

Emergency Contact Information

Emergency Contact:	Phone #:
Relationship to patient:	
How did you hear about us? Physician Friend/Family Phonebook Walk-In Website Other: _____	

Patient/Guardian Signature

I certify that the information provided above is true.	
Patient/Guardian Signature:	Date:



D&D Sports Med Medicare Patient Information

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Have you had any physical therapy, occupational therapy, speech therapy, or chiropractic care since the beginning of this calendar year? Yes _____ No _____

If yes, approximate dates: _____ Where? _____

Have you received **any type** of Home Health Care in the last calendar year? Yes _____ No _____

If yes, with what agency? _____ When were you discharged? _____

Have you been in a skilled nursing inpatient facility in the last calendar year? Yes _____ No _____

If yes, with what facility? _____ When were you discharged? _____

Have you been admitted to a hospital in the last calendar year? Yes _____ No _____

If yes, with what facility? _____ When were you discharged? _____

Do you have Medigap insurance? Yes _____ No _____

Is your present illness/injury resulting from a motor vehicle accident? Yes _____ No _____

If yes, please provide the following: date & time of accident: _____

Is the accident work related? Yes _____ No _____

If yes, are you covered by Workers Comp? Yes _____ No _____

Was the injury caused by other type of accident? Yes _____ No _____

If yes, please explain: _____

Name of owner of the property where accident occurred: _____

If applicable, please complete the following:

Name & address of auto insurance:

Name & address of liability insurance

Name & address of any attorneys you have retained: _____

Are you currently employed? Yes _____ No _____

Is your spouse currently employed? Yes _____ No _____

Does your spouse cover you under his/her policy? Yes _____ No _____

Are you disabled and under age 65? Yes _____ No _____

Are you covered under the veteran's administration? Yes _____ No _____

Are you covered by Medicare under black lung? Yes _____ No _____

Patient's Signature

Date

Guardian Sig. if applicable



D&D Sports Med Medical History Form

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Patient's Name: _____ Patient's Age: _____

Describe the current symptoms for which you are seeking therapy: _____

Date of Injury/onset of condition: _____

Have you ever experienced these symptoms before? Yes (When) _____ No _____

Describe your symptoms (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Loss of strength | <input type="checkbox"/> Better with activity |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Loss of motion | <input type="checkbox"/> Constant pain |
| <input type="checkbox"/> Balance Loss | <input type="checkbox"/> Worse in AM | <input type="checkbox"/> Night pain |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Worse in PM | <input type="checkbox"/> Other: _____ |

Please rate your pain from 0-10 (0= no pain; 10 = emergency room pain)

Current = _____ Best = _____ when I _____ Worst = _____ when I _____

List 3 things you are unable to do as a result of your condition:

1. _____
2. _____
3. _____

What activities increase your symptoms? (Check all that apply)

- | | | | |
|---------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Rising from chair | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Rolling over in bed |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Grasping | <input type="checkbox"/> Writing | <input type="checkbox"/> Lying on side |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Running | <input type="checkbox"/> Throwing | <input type="checkbox"/> Cough/sneeze/strain |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Dressing | <input type="checkbox"/> Housework | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Other: _____ | | | |

Please indicate if you are currently experiencing any of the following (Check all that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Fever/sweats/chills |
| <input type="checkbox"/> Malaise | <input type="checkbox"/> Weakness | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Night pain |
| <input type="checkbox"/> Changes in urinary/bowel frequency | | | |

Tests and Results:

- | | | | | |
|------------|-------|----|----------------|-------------|
| 1. X-Rays | YES | NO | Results: _____ | Date: _____ |
| 2. MRI | YES | NO | Results: _____ | Date: _____ |
| 3. CT Scan | YES | NO | Results: _____ | Date: _____ |
| 4. EMG | YES | NO | Results: _____ | Date: _____ |
| 5. Other: | _____ | | Results: _____ | Date: _____ |

Have you had surgery related to this condition? Yes _____ No _____

If yes, type of surgery: _____ Date of surgery: _____

Work History:

Are you presently working? Yes No If no, how many total days of work have you missed? _____

Are your work duties? Full Restricted How many hours per week do you work? _____

Who is your employer? _____ What type of work do you do? _____

What critical work duties have been most affected by your injury/condition? _____

Please Indicate how you sustained this condition:

- | | |
|---|--|
| <input type="checkbox"/> Work related injury | <input type="checkbox"/> Recurrence of prior condition |
| <input type="checkbox"/> Cause unknown | <input type="checkbox"/> Injury related to lifting |
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Chronic |
| <input type="checkbox"/> Athletic/Recreation Injury | <input type="checkbox"/> OTHER: _____ |

Please list any other surgeries you have had, including type and date: _____

Have you had any physical therapy, occupational therapy, or chiropractic care since the beginning of this calendar year (including home health)? Yes _____ No _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | | | |
|----------------------------|-------------------------|---|-------------------------|
| Diabetes | Self _____ Family _____ | Allergies: _____ | Self _____ Family _____ |
| Chest Pain/Angina | Self _____ Family _____ | Thyroid Problems | Self _____ Family _____ |
| Heart Disease | Self _____ Family _____ | Osteoporosis/Osteopenia | Self _____ Family _____ |
| High Blood Pressure | Self _____ Family _____ | Arthritis | Self _____ Family _____ |
| Heart Attack | Self _____ Family _____ | Metal Implants | Self _____ Family _____ |
| Pacemaker | Self _____ Family _____ | Recent Fractures | Self _____ Family _____ |
| Vascular Disease | Self _____ Family _____ | Hernia | Self _____ Family _____ |
| CVA/Stroke/TIA | Self _____ Family _____ | Infectious Disease | Self _____ Family _____ |
| Seizures | Self _____ Family _____ | Dizziness/Fainting | Self _____ Family _____ |
| Headaches | Self _____ Family _____ | Nausea/Vomiting | Self _____ Family _____ |
| Kidney Problems | Self _____ Family _____ | Skin Abnormalities | Self _____ Family _____ |
| Cancer: _____ | Self _____ Family _____ | Sexual Dysfunction | Self _____ Family _____ |
| Bowel/Bladder Problems | Self _____ Family _____ | Ringling in your Ears | Self _____ Family _____ |
| Asthma | Self _____ Family _____ | Depression | Self _____ Family _____ |
| Liver/Gallbladder Problems | Self _____ Family _____ | Anxiety | Self _____ Family _____ |
| Special Dietary Guidelines | Self _____ Family _____ | Do you use tobacco? | Self _____ Family _____ |
| Are you Pregnant? | Yes _____ No _____ | If Yes. How long have you used tobacco? | _____ |
| Fibromyalgia | Self _____ Family _____ | Average weekly usage: | _____ |
| Concussion | Self _____ | | |

If you answered "yes" to any of the above, please explain and give approximate dates: _____

Do you participate in any sports, exercise program, or activities on a regular basis? Yes _____ No _____

If yes, please describe: _____

Is there any other information regarding your past medical history that we should know about? _____

Have you experienced any falls in the last 12 months? Yes _____ No _____ If yes, how many? _____

Have you been injured from a fall during the last 12 months? Yes _____ No _____

When are you scheduled to see your doctor again? _____

<u>FOR OFFICE USE:</u>
Clinician's Initials: _____
Today's Date: _____

To the best of my knowledge and belief, the information I have given above is accurate and true.

Patient's Signature Today's Date Parent/Guardian Signature if applicable



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PATIENT INFORMATION CONSENT FORM

I have been provided with a copy of **D&D Sports Med**'s Notice of Information Practices. I understand that **D&D Sports Med** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that D&D Sports Med's PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **D&D Sports Med**'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

I hereby consent to the release of personal health information (verbal or written) regarding my treatment and/or account information for services rendered at D&D Sports Med to the following individual(s):

Person's Name

Relationship to you

Person's Name

Relationship to you

Person's Name

Relationship to you

My signature

Today's Date



D&D Sports Med Medicare Benefits Acknowledgment

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As a Medicare patient, I am aware that I have a \$183.00 deductible for 2017 that must be met prior to Medicare initiating payments.

I am also aware that Medicare pays 80% of their contracted rate and that I am responsible for the remaining 20%. D&D Sports Med has agreed to file on any secondary insurance I may have, but depending on my secondary coverage, a balance may remain after my secondary insurance processes the claims.

I am aware of these financial responsibilities, and agree to pay for these services as outlined in the Medicare fee guidelines should a balance remain.

Patient's signature

Today's date



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D&D Sports Med Financial Policy

Thank you for choosing D&D Sports Med as your Physical/Occupational Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.

Payment for services is due prior to or upon completion of each treatment visit. We accept CASH, MASTERCARD, VISA, AMERICAN EXPRESS, or PERSONAL CHECKS. Once your complete insurance information is on file, we will happy to submit your claims to your insurance company. _____ INITIALS

REGARDING PRIVATE INSURANCE:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered. Unpaid balances are subject to 10% interest, accrued monthly.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee provided by the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment. If an overpayment from you is discovered, you will be refunded once all claims for all dates of service are processed. There is a \$5.00 fee for re-processing an un-deposited refund check as long as it is dated with a year from the request. Any un-deposited refund checks that are more than a year old will not be reprocessed.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim. _____ INITIALS

NON-COVERED EXPENSES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses. _____ INITIALS

MISSED APPOINTMENTS

Please notify us within 24 hours in advance to cancel your appointment. Failure to notify us within 24 hours (48 hours over a weekend) or no-showing for an appointment may result in a \$30.00 cancellation fee. It is our policy to reschedule any cancelled appointments at the time of your call. Attending your scheduled appointments is crucial to successful treatment and recovery from your injury. _____ INITIALS

INFORMATION

I give permission to D&D Sports Med to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize D&D Sports Med to obtain medical records from my physician or other medical professionals as it relates to my treatment. _____ INITIALS

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment.

Patient's Signature

Parent/Guardian Signature

Witness' Signature

Date of signatures