



**D&D SPORTS MED**  
DENTON · SANGER · AUBREY

**DENTON** - 2318 San Jacinto Blvd., Suite 108  
P: (940) 380-9111 F: (940) 380-9112

**SANGER** - 1650 W. Chapman, Suite 400  
P: (940) 458-2611 F: (940) 458-2619

**AUBREY** - 26875 East Hwy. 380, Suite 124  
P: (972) 347-6000 F: (972) 347-6001

## **Welcome to D&D Sports Medicine!**

We're happy you have chosen us to provide your outpatient physical therapy. We are committed to helping you meet your personal health goals through physical therapy via a customized clinical process as well as to educate you on your condition to help you prevent recurrence.

### **What to Expect:**

As part of your orientation, your first visit will consist of a complete Physical Therapy evaluation. We will discuss your physical history, current condition and perform a complete physical examination. The physical examination will consist of specialized tests designed to assess your body mechanics as well as your strengths and weaknesses. This will enable our therapists to develop an individualized program specifically designed to treat your diagnosis limitations.

You will be asked to complete periodic evaluation forms so that we can accurately assess your progress, and we will provide your doctor with a report of your progress.

### **What to Wear:**

Be prepared to move around a lot during your first physical therapy session. With that in mind, we recommend that you wear looser-fitting clothing and sneakers for maximum comfort.

**Please complete the attached forms and bring them to your initial appointment.**

### **Please also bring the following:**

- Your referral or prescription from your doctor for physical therapy
- Your driver's license or other photo ID.
- Your insurance card(s)

### **Appointments:**

- Please be sure to arrive at least 15 minutes prior to your initial evaluation to complete intake paperwork.
- It is important to the recovery process that you keep all your prescribed appointments. Should you need to cancel, kindly notify our office **at least 24 hours** in advance.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all our clients and you may be asked to reschedule your appointment if you arrive more than 10 minutes late.

If you have any questions or need to change the date or time of your appointment, please call our office and we will be happy to make the adjustment for you.

Thank you for choosing D&D Sports Medicine; we look forward to working with you!



### Patient Intake Form

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(last) (first) (MI)

Mailing Address \_\_\_\_\_  
(number and street) (city) (state) (zip)

Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

Email address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Date of Injury \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**► Insurance – please provide your card- if card is on file please skip**

Primary Insurance Name and Address \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Name and Address \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

► Workers Compensation Carrier ◀ \_\_\_\_\_ Claim # \_\_\_\_\_

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

### **Authorization & Consent**

- I understand that I am responsible for all charges incurred regardless of insurance or third-party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize D&D Sports Medicine to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3<sup>rd</sup> party agency and/or attorney for collections or legal action.
- I authorize my insurance company or any other concerned third party to make payment directly to D&D Sports Medicine.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**Patient History Form**

\*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ BMI: Height \_\_\_\_\_ Weight \_\_\_\_\_

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of last Physician exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**History of Present Problem**

What is the main reason for your Physical Therapy evaluation today?

\_\_\_\_\_

\_\_\_\_\_

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable) circle the number that best describes your average pain

0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?  
days ago weeks ago months ago years ago  
Other \_\_\_\_\_

Please mark the location of the pain on the diagram below.

Problem **worsens** with:  
Movement Inactivity Standing Lying Sitting  
Other \_\_\_\_\_

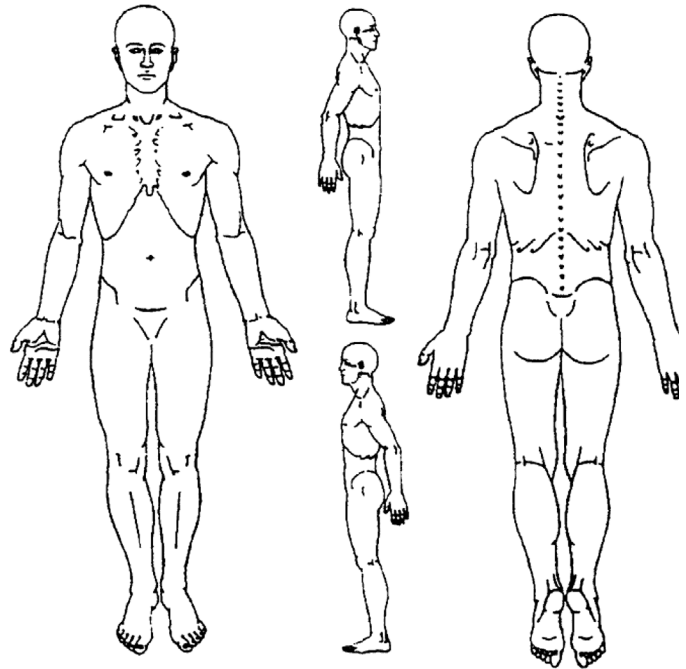
Problem **improves** with:  
Movement Inactivity Standing Lying Sitting  
Rest Medication Heat Ice  
Other \_\_\_\_\_

How frequently are you bothered by this problem?  
Constant Occasional/Variable  
Other \_\_\_\_\_

How would you describe the problem?  
Dull Sharp Dull then Sharp  
Very sharp then stops  
Other \_\_\_\_\_

Do you have any other symptoms?  
No Yes (please explain) \_\_\_\_\_

Does the problem interfere with daily functions?  
No Yes (please explain): \_\_\_\_\_





### Medical History

Do you now or have you ever had (please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> High Cholesterol  |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Hypothyroidism  |
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Incontinence  |
| <input type="checkbox"/> Anxiety/Panic Disorders   | <input type="checkbox"/> Jaundice  |
| <input type="checkbox"/> Arthritis (rheumatoid/osteoarthritis)                                     | <input type="checkbox"/> Joint Pain/Swelling   |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Kidney/Bladder/Prostate/Urination Problems                  |
| <input type="checkbox"/> Back Pain (neck pain/back pain/degenerative disc disease/spinal stenosis) | <input type="checkbox"/> Multiple Sclerosis / Parkinson's/ Any Neurological Disease  |
| <input type="checkbox"/> Cancer (Type: _____)  | <input type="checkbox"/> Leukemia  |
| <input type="checkbox"/> CHF/Any Heart Disease/Heart Murmur  | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Chronic Headaches   | <input type="checkbox"/> Other Disorders   |
| <input type="checkbox"/> Colitis   | <input type="checkbox"/> Paralysis   |
| <input type="checkbox"/> Convulsion  | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> COPD/ARDS/Emphysema   | <input type="checkbox"/> Pneumonia   |
| <input type="checkbox"/> Crohn's Disease   | <input type="checkbox"/> Previous Accidents  |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Prior Surgery   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Prosthesis/Implants   |
| <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Fractures   | <input type="checkbox"/> Pulmonary Embolism  |
| <input type="checkbox"/> Gastrointestinal Disease (ulcer/hernia/reflux/bowel/liver/gallbladder)    | <input type="checkbox"/> Visual Impairment (cataracts/glaucoma/macular degeneration) |
| <input type="checkbox"/> Goiter  | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Sleep Dysfunction   |
| <input type="checkbox"/> Hearing Impairment/Hearing Aids   | <input type="checkbox"/> Stomach or Peptic Ulcer                                     |
| <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Stroke/TIA  |
| <input type="checkbox"/> Hepatitis/AIDS/HIV  | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> PVD (Peripheral Vascular Disease)                           |

- Do you wear dentures?  Yes  No
- Do you wear glasses/contacts?  Yes  No
- Do you have a pacemaker?  Yes  No
- Do you have any skin allergies?  Yes  No
- Do you have any discomfort/shortness of breath/pain with exercise?  Yes  No
- Do you smoke?  Yes  No If yes how much do you smoke? \_\_\_\_\_
- If you quit smoking, when did you quit? \_\_\_\_\_
- Is there a chance that you may be pregnant at this time?  Yes  No
- List any allergies to medication: \_\_\_\_\_
- List any hospitalizations/reasons/dates: \_\_\_\_\_
-



**Medications**

In order to gain a more comprehensive view of your condition, we need to know what medications you are taking. This includes **prescription medications, over the counter medications, vitamins, and any other supplements**. If you are not taking any of the above, please write "NONE". (You may bring a different list, but it **MUST** include all of the required information)

Name of Medication (Name of drug on package)	Dosage (usually in mg. or ounces, etc.)	Frequency (Daily, 2 X day, etc.)	Route of Administration (Orally, injection, etc.)	Changes or Comments
EXAMPLE: Coumadin	3 mg.	Daily	Orally	BIW as of 1/15/22

I attest that the above information is correct and true to the best of my ability. I acknowledge that I should inform my therapist of any changes that occur in medication while I am a patient at D&D.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**D&D SPORTS MED**  
DENTON · SANGER · AUBREY

## Financial Policy & Consent to Treat

This is an agreement between D&D Sports Medicine and (print name) \_\_\_\_\_.

In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to D&D Sports Medicine.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

**Collection Policy:** If you allow your patient balance to go 120 days without making payment arrangements, you will be sent to a collection agency. If your balance is sent to collections, you will also be responsible for a 30% fee in addition to your balance.

### **Payment options if you have insurance:**

1. If you have a deductible to meet, you choose to pay by check or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for any additional patient responsibility, if any, which is determined by your carrier.
2. You choose to pay your co-payment, determined by your insurance carrier, by check or credit card at the time services are rendered. If there is a balance on your account at the end of the month, we will bill you accordingly
3. **Payments:** Unless other arrangements are approved, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month. If extenuating circumstances should arise, you can discuss a payment plan with our Billing Department 330-702-0110 ext. 149 or [inquiries@lincolnrs.com](mailto:inquiries@lincolnrs.com).

### **Consent For Care & Treatment**

I, the undersigned, do hereby agree and give my consent for D&D Sports Medicine to furnish medical care and treatment to \_\_\_\_\_ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**Insurance & Fee Notice**

**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your coverage eligibility. Our billing company will verify your benefits with your insurance company and determine if a preauthorization is required.

**Non-contracted Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your coverage eligibility. You agree to pay any portion of the charges not covered by insurance.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

**Returned Checks:** There is a \$25 fee for any checks returned by your bank.

**Missed Appointments:** If you find that you cannot keep your scheduled appointment, we ask that you cancel at least 24 hours in advance. **Failure to cancel with at least 24 hours' notice or "no shows" will result in a cancellation fee of \$50.00 per appointment.** This charge must be paid in full before receiving further treatment.

**Workers Compensation:** We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

**Motor Vehicle Accidents:** If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



## HIPAA Notice of Privacy Practices

This 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.

### **Uses and Disclosure of Health Information:**

We will use and disclose your health information in order to treat you or to assist other health care 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 limited operational activities such as quality assessment, licensing, accreditation and training of students.

### **Uses and Disclosures Based on Your Authorization:**

Except as stated below, we will not use or disclose your health information without your written authorization.

### **Uses and Disclosures Not Requiring your Authorization:**

In the following circumstances, we may disclose your health information without your written authorization:

- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

### **Patient Rights:**

As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or 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 with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

**Please contact us with any questions, concerns, or complaints regarding our privacy practices.**

**I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**





**D&D SPORTS MED**  
DENTON · SANGER · AUBREY

**Patient Talent Release**

I, (please print) \_\_\_\_\_, hereby grant permission to **D&D Sports Medicine** to create, copy, reproduce, exhibit, publish or distribute my written testimonial or photographic image/video. I understand that the above uses may include, but are not limited to film, photographs, print, websites, multi-media programs, social media or other types of promotional medium existing now or in the future.

I further understand that by granting this permission I am giving up all rights and claims to monetary compensation for any future use of this material by **D&D Sports Medicine**.

**Patient Name (Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
(Print name of parent or guardian if person is under 18 years old)

A parent or guardian signing is doing so individually and on behalf of the minor and warrants he/she has the authority to sign on behalf of the minor.

**Signature:** \_\_\_\_\_  
(Signature of parent or guardian individually and on behalf of the minor)

**Date:** \_\_\_\_\_

**How Did You Hear About Us?**

Physician \_\_\_\_\_ Name of Physician: \_\_\_\_\_

Repeat Patient \_\_\_\_\_

Friend/Family \_\_\_\_\_ Name of Friend/Family Member: \_\_\_\_\_

Google/Search Engine \_\_\_\_\_

Website \_\_\_\_\_

Social Media \_\_\_\_\_

Advertisement \_\_\_\_\_

Event \_\_\_\_\_

Other \_\_\_\_\_