MEDICAL & SPORTS REHABILITATION CENTER

Name: _____ _____ _____
(First) (Middle) (Last)

Nickname:_____ **Gender**: ☐ M ☐ F

Date of Birth (Month/Day/Year):_____ **Age:**_____**Soc. Sec #**: _____

Emergency Contact:_____ _____
(Name) (Phone #)

Emergency Contact Relation (spouse, friend, parent, etc):_____

Local Address: _____ _____
(Street) (Apt, Ste, Unit)

_____ _____ _____
(City) (State) (Zip Code)

Northern Address: _____ _____
(Street) (Apt, Ste, Unit)

_____ _____ _____
(City) (State) (Zip Code)

Email Address:_____
We can send you email reminders regarding your appointment day & time. Please provide us with your email so we may help you keep track of your therapy appointments.

Phone: _____ _____ _____
(Home) (Northern Phone) (Work)

_____ ***NOTE***: We can send you text reminders regarding your appointment day & time.
(Cell)
Please let us know your cell phone carrier if you would like these reminders to be sent. _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer:_____
Is the illness/injury for which you are being seen the result of any of the following?

☐ Auto Accident ☐ Work Injury ☐ Other Litigation ☐ None of these

Is there an attorney involved in relation to your injury/illness? ☐ YES ☐ NO

If yes: _____ _____
(Name of Attorney) (Attorney's Phone #)

Name: _____ _____ _____
(First) (Middle) (Last)

PATIENT SIGNATURE & ACKNOWLEDGEMENT

Please read and **INITIAL** the following:

_____I consent to ***evaluation & treatment*** by Medical & Sports Rehabilitation Center, Inc and realize I have the right to refuse any procedure after having the risks & benefits explained to me.

_____ To the best of my knowledge the information I provided on the "History Questionnaire" is complete and factual.

_____I authorize the ***release of information*** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or third party payer.

_____I authorize ***phone messages*** regarding my treatment & appointments to be left with persons or machines at the phone numbers I have provided.

_____I authorize ***text messages*** regarding my treatment & appointments to be sent to the cell phone number I have provided.

_____I authorize ***email messages*** regarding my treatment, appointments, and important messages to be sent to the email address I have provided.

_____ I have read, understand, and agree to the financial policies of Medical & Sports Rehabilitation Center, Inc. (Does not apply to WC or VA patients)

_____ A copy of this facility's ***Statement of Privacy Notice*** has been provided to me. You may find this brochure in our waiting area.

_____I hereby instruct and direct my insurance company to pay Medical & Sports Rehabilitation Center, Inc for services received. If my current policy prohibits direct payment to the above medical provider, I also instruct and direct the check be sent to Medical & Sports Rehabilitation Center, Inc. I authorize Medical & Sports Rehabilitation Center to deposit any check that is received for my account when it is made out to me. A photocopy of the Assignment shall be considered as effective and valid as the original. (Does not apply to WC or VA patients)

_____I authorize Medical & Sports Rehabilitation Center, Inc to discuss my account with the following person/s (for example: husband, personal assistant, etc). I understand that if I do not list anyone then my account may only be discussed with me.

_____ _____
(Authorized Person) (Relation)

Patient's Signature: X_____ Date:_____

Signature of Responsible Party:_____ Date:_____
(If different from patient)

Relation to Patient:_____

Name:_____ _____ _____
(First) (Middle) (Last)

PATIENT HEALTH HISTORY QUESTIONNAIRE

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

SOCIAL HISTORY

Primary Language:_____

Occupation:_____

Work Status (Please Check One):

☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Not Employed

☐ Disabled ☐ Retired ☐ Student

Social Activities (interests/hobbies/exercise):_____

_____

Support System (who at home can help you if needed):_____

Referring Physician (who sent you to therapy?):_____

Primary Care Physician (if applicable):_____

Next scheduled Dr Appointment (Date):_____

CURRENT MEDICATIONS

Please provide us with a current list of your medications and/or herbal supplements or list them below

_____ _____

_____ _____

_____ _____

Name:_____ _____ _____
(First) (Middle) (Last)

CURRENT & PAST MEDICAL HISTORY

Do you have any allergies (adhesives, latex, cortisone, medications)? ☐ YES ☐ NO

If yes, please list with any reaction/treatments:

_____ Reaction/Treat_____

_____ Reaction/Treat_____

_____ Reaction/Treat_____

Place a "CHECK MARK" next to the condition/s that apply to you.

☐	Diabetes	☐	Neurological Disorder	☐	Anxiety
☐	Heart Disease	☐	Stroke	☐	Depression
☐	Pacemaker	☐	Parkinson's	☐	Panic Attacks
☐	High Blood Pressure	☐	Epilepsy	☐	HIV/AIDS
☐	Shortness of Breath	☐	Hearing Difficulties	☐	Hepatitis
☐	Lung Problems	☐	Visual Difficulties	☐	MRSA
☐	Unexplained Weight Change	☐	Stomach or Bowel Disorders	☐	Staph

I ☐ have or I ☐ had CANCER (please check have or had): ☐ YES ☐ NO

Location/Body Part with Cancer:_____

I am still currently being treated for cancer: ☐ YES ☐ NO

I have been diagnosed with ARTHRITIS: ☐ YES ☐ NO

Location/Body Part with ARTHRITIS:_____

I have been diagnosed with OSTEOPOROSIS: ☐ YES ☐ NO

Location/Body Part with OSTEOPOROSIS:_____

I have had a JOINT REPLACEMENT: ☐ YES ☐ NO

Location/Body Part of JOINT REPLACEMENT:_____

Please describe any other problems not listed above:_____

Name:_____ _____ _____
(First) (Middle) (Last)

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** problem?

_____

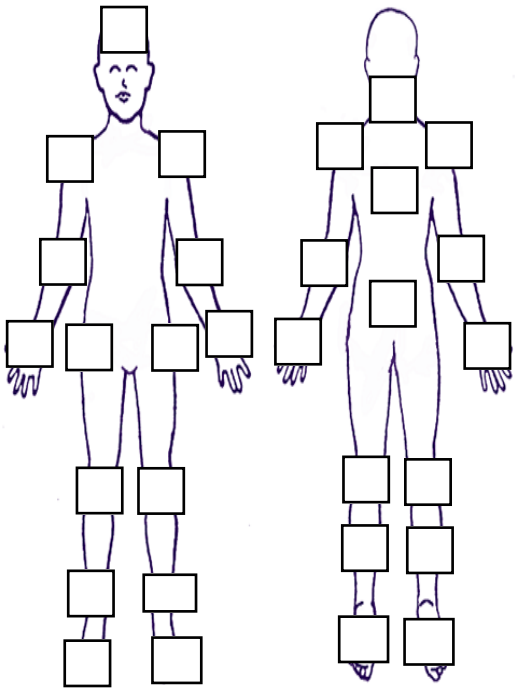
Check the box that describes your pain level **AT REST**
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Check the box that describes your pain level **WITH ACTIVITY**
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Place check marks on the body where you have pain or numbness.



Please indicate your present level of difficulty for each area listed below by checking the appropriate box for each activity.

	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Exercise	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing (Getting up from sitting)	☐	☐	☐	☐	☐
Personal Care (Dressing/Bathing)	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐
Social Life (Recreational & Social Activities)	☐	☐	☐	☐	☐
Traveling	☐	☐	☐	☐	☐

Name: _____ _____ _____
(First) (Middle) (Last)

APPOINTMENT CANCELLATION POLICY

Dear Medical & Sports Rehab Patient:

Medical & Sports Rehabilitation Center Inc (MSRC) has a twenty-four (24) hour cancellation & missed appointment policy. You must contact our office 24 hours prior to your appointment to cancel your appointment.

Your account will be charged a $40.00 cancellation fee if:

1. You do not give us twenty-four (24) hour notice prior to cancelling
2. You do not show up to your scheduled appointment

We understand that at times there may be extenuating circumstances that will not permit you to call twenty-four (24) hours in advance. Our billing department will be happy to discuss this with you. You may contact our billing department at 239-261-0291.

Thank you for your understanding.

I have read and understand the appointment cancellation policy.

_____
Patient Signature

_____
Date

Name: _____ _____ _____
(First) (Middle) (Last)

FINANCIAL POLICIES

Medical and Sports Rehab is very concerned about the cost of health care. Great care has been taken in setting fees for our services. Our charges accurately reflect the complexity of care rendered and the skill and expertise required for care. *The information below sets forth the financial policies of Medical & Sports Rehabilitation Center.*

PRIVATE PAY(CASH): If you **DO NOT** have insurance coverage or **DO NOT** wish us to bill an insurance company, payment will be required at the time of each service. We accept cash, personal check, debit cards, Visa, MasterCard, and Discover.

***WALK-INS*:** Our office calls to verify benefits prior to any appointment. It is possible that your insurance company has certain restrictions that may limit payment if you chose to be seen as a walk-in. Pre-certification requirements may apply and treatment will not be covered unless our office obtains authorization prior to treating you. **You will be responsible for payment of today's visit if you choose to be seen without our office obtaining benefit information prior to your treatment**.

INSURANCE COMPANY: We bill your insurance company as a **COURTESY** to you, on the condition that you have provided us with the correct billing information including name, address, phone number, and claim/policy numbers. It is your RESPONSIBILITY to know what your plan covers and if there are any "special conditions" that your insurance company requires for payment. We will call your insurance company to verify benefits as a COURTESY to you, but frequently the information provided is not accurate. We will not know if the information is truly correct until we receive your first explanation of benefits, which is 30 days after your initial visit. Verification of benefits is not a guarantee of payment or your assigned patient responsibility. We recommend you contact your insurance provider to verify benefits for outpatient therapy services.

You must also be aware that:

1. ***You are responsible for what your insurance does not pay, including applicable deductibles, co-payments and/or the percentage not covered by your plan***. ***Payment is due AT THE TIME OF EACH VISIT*.**
2. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for these services should your insurance not cover them.
4. If your deductible has NOT BEEN MET for the plan year, you will be REQUIRED TO PAY for services as they are rendered. We will submit your claims to the insurance company as a courtesy to you so that they will be applied toward your deductible.

MEDICARE: There is a cap in effect for outpatient physical, occupational, and speech therapy. You are responsible for keeping track of your medical expenses so that you do not exceed the cap. Medical & Sports Rehabilitation Center, Inc. will be happy to provide you with updates upon request. Medicare will cover 80% of physical and occupational therapy services. You will be responsible for the remaining 20% after Medicare. We will bill your secondary insurance (if applicable) **as a courtesy to you**, provided we have the correct name, address, and phone number for the insurance company. **Again, you will be responsible for what your co-insurance does not pay of the 20% and any deductibles.** If your secondary/supplemental insurance pays you for the 20%, then we require you to pay us the 20% or any deductible at the time of service. We will confirm this when we call to verify your benefits. Please remember that a quote of benefits from your insurance is not a guarantee of payment.

***LATE FEES*:** Medical & Sports Rehab Center has a 20-day billing cycle. You have 20 days from the date on the statement to make your payment. A **$10.00 late fee will be assessed each time** we must re-bill you for services rendered. You must contact our billing department if you are unable to make a payment on your account.

RETURNED CHECKS: You will be assessed a $25.00 fee for each check that is returned to us by your bank.

We must emphasize as a care provider, our relationship is with you, not your insurance company. You are ultimately responsible for payment for services rendered, regardless of insurance, regardless of outcome. We accept cash, personal checks, debit cards, Visa, MasterCard, and Discover. If you have any questions, please do not hesitate to contact our Billing Department at (239) 261-0291.