S.P.O.R.T.S.

Scott Pensivy Orthopedic Rehabilitation Therapy Services

Welcome to our office

We would like to welcome you as a patient. We realize that no one really wants to be here, but we hope your time here is informative and provides future health benefits. Your initial visit will consist of a thorough examination to determine the needs and best activities for your recovery. At some point during your treatment , you may go to our gym facility. Please wear or bring proper gym attire. Lockers and showers are available in the men's and women's restrooms at the Cheyenne location only. We encourage you to ask any questions regarding your care. Our staff is here to work with you as a team, to ensure you receive the best care. Our pledge is to provide clinical and customer service excellence with each visit. We want you to have a positive experience here at S.P.O.R.T.S.

Authorization for Treatment

Physical therapy services offered at S.P.O.R.T.S. includes, but not limited to: evaluation techniques, soft tissue techniques, manual therapy techniques, heat, cold, electrical stimulation, electrical modalities, paraffin, stretching activities, strengthening exercises, cervical/lumbar traction, and the use of gym and/or Pilates equipment.

I have been informed that if any soft tissue technique, particularly Graston technique / active release / cross-fiber friction mobilization, are used, it may cause bruising and tenderness in the region that is/was treated. If the technique is too uncomfortable I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

I consent to the rendering of physical therapy care by S.P.O.R.T.S. I also understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy may involve some risk and I hereby release S.P.O.R.T.S. from liability now or in the future.

Assignment of Insurance Benefits and Release of Information

I hereby assign and authorize direct payment to S.P.O.R.T.S. of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original.

Personal Valuables/Dependents/Visitors

It is understood and agreed that S.P.O.R.T.S is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

Financial Agreement

I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that S.P.O.R.T.S. bills participating insurance companies as a courtesy. I understand that all copayments, coinsurance, deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my full responsibility to know and understand my health plan. I understand that S.P.O.R.T.S. is not responsible for any inaccurate information they receive from my insurance co. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to S.P.O.R.T.S., if required by my insurance. Should the account be referred to an agency or attorney for collections, I agree to pay attorney's fees and collection expense. I agree to pay $25 for any returned checks.

Cancellation / No-Show Policy

Missed appointments represent a cost to S.P.O.R.T.S., to you, and to other patients who could have been seen in the time slot set aside for you. Cancellations are requested 24 hours prior to the appointment time. We reserve the right to charge for missed or late-canceled appointments. Excessive cancellation/no-show of appointments may result in discharge from the practice. If you need to cancel or reschedule an appointment, please feel free to call us during our business hours. Cheyenne: 702.655.8535 Fort Apache: 702.538.8057. I agree to pay $10 for all physical therapy appointments that are not canceled 24 hours prior to my scheduled treatment session.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. You may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

I

HAVE FULLY READ AND UNDERTSAND ALL THE ABOVE CONTENTS AND AGREE TO ACCEPT ITS TERMS

Signature of Patient or Responsible Party	Print Name	Date

Date: _______/______/__________

Name: ____
(LAST) (FIRST) (MIDDLE)

Address: ____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( ) _________-__________ Work Phone: ( ) ________- _________ Cell: ( ) _______-_________

SSN: _______-_______-________ Date of Birth: _______/______/_________ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Employer: ____ Occupation: _________________________________

Employer's Address: ____
(STREET) (CITY) (STATE) (ZIP)

Referred By: ____ Area of Injury: _______________________

Type of Injury: Work Related Sports Injury Auto Accident Other: ______________________________

Your email address: ____

SPOUSE AND/OR GUARDIAN INFORMATION

Name: ____ D.O.B.______/_____/______ SSN: ________-____-________

Relationship: _________________________ Employer: ________________________ Occupation:___________________

Emergency Contact: ___________________________ Relationship: ______________ Phone #: ___________________

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Name: ____

Address: ____Phone#: ____________________

Name of Insured: ________________________________ ID# ________________________ Group# _________________

SECONDARY INSURANCE
Insurance Name: ____

Address: ____Phone#: ____________________

Name of Insured: ________________________________ ID# ________________________ Group# _________________

RECORDS RELEASE

To: ______________________________

This request comes to your office on behalf of: ______________________________
We are currently seeing him/her for physical therapy treatment and are in need of his/her records from your office.

I hereby authorize S.P.O.R.T.S. Physical Therapy to inquire and request documents on my behalf regarding my care.

Patient Signature : ______________________ Date: __________

Please Print Name: ______________________________

For office use only
Dated: ______________________ Coded: __________
Rqts: ______________________ Initials: __________

Name: ____ Age: _______ Height: _______ Weight: _______
Social Security #: ____________________________ Occupation/School: ________________________________
Referring Physician / Clinician: ________________________________ Diagnosis: _________________________

REASON FOR VISIT

1. How did the present injury occur____
2. When did the condition begin? ______/_____/_____
3. Did you have surgery for this condition? YES NO If yes, when? _____/_____/_____
4. Please list your chief complains: (i.e. symptoms / problems with daily activities)
   ____
   ____
   ____
5. What aggravates this condition____
6. What alleviates the symptoms of this condition?____
7. Have you had this or a similar condition in the past? YES NO
   If yes, please explain:____
8. Have you had previous treatment for this condition? YES NO
   If yes, please explain: ____
9. Does this condition interfere with your (please circle): WORK SLEEP DAILY ROUTINE
   If so, please explain:____

MEDICAL HISTORY

1. Have you been by another clinician (i.e. doctor, dentist, psychiatrist, psychologist, chiropractor) during the last six months? YES NO If yes, please explain: ____
2. Please list any medications you are currently taking:____
   ____
3. Do you have or ever had any of the following diseases or conditions?

Heart Attack	Stroke	Cancer
Diabetes	Hepatitis	Emphysema
Anemia	Arthritis	Alcohol/Drug Abuse
HIV/Aids	Tuberculosis	Multiple Sclerosis
Kidney Problems	Thyroid Problems	Asthma
High Blood Pressure	Epilepsy / Seizures	Shingles
Artificial Bones / Joints	Frequent Neck Pain	Lower Back Problems

4. Have you had any other orthopedic injuries / surgery? YES NO
   If yes, please explain:____
5. Do you smoke? YES NO How much? _______ How long? _________
6. Are you on a special diet? YES NO
7. Are you taking any supplements / vitamins? (Please list)____
8. Do you exercise regularly? YES NO How much?___________ How often?_______________
9. Do you have any of the following problems with exercise?
   If yes, please circle: Chest Pain Dizziness Nausea Shortness of Breath

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