NEW PATIENT PAPERWORK

NAME_____ M F

HOME # _____WORK #_____CELL#_____

ADDRESS_____CITY_____ ZIP _____

SOCIAL SECURITY#_____DATE OF BIRTH_____

E-MAIL ADDRESS_____

WOULD YOU LIKE US TO SEND YOUR BILLING STATEMENTS TO YOU VIA E-MAIL? **YES** **NO**

POLICYHOLDER'S NAME (if other than self)_____

POLICYHOLDER'S DOB_____ SOCIAL SECURITY#_____

EMERGENCY CONTACT _____

EMERGENCY CONTACT PHONE# _____ RELATIONSHIP_____

IS THERE AN ATTORNEY INVOLVED? **YES** **NO**

IF YES PLEASE PROVIDE THEIR NAME AND PHONE# BELOW:

_____

HAVE YOU HAD HOME HEALTH? **YES** **NO** IF YES, WHEN WERE YOU DISCHARGED_____

IN ORDER TO PROVIDE YOU WITH THE BEST CARE, WE CAN PUT THE CO-PAYMENTS YOUR INSURANCE COMPANY REQUIRES ON A BUDGETED PAYMENT PLAN. THIS BUDGET WOULD ALLOW YOU TO PAY A SMALLER AMOUNT EACH VISIT AND PAY OFF THE REMAINING ACCRUED BALANCE MONTHLY, ONCE YOUR THERAPY IS COMPLETED.

WOULD YOU LIKE YOUR CO-PAYMENTS PLACED ON A BUDGET? **YES** **NO**

PLEASE SEE BACK OF PAGE FOR REQUIRED SIGNATURES

CONSENT FOR TREATMENT

I HEREBY GIVE MY CONSENT FOR TREATMENT RENDERED BY THERAPY AND SPORTS CENTER INC. TO MYSELF/DEPENDENT AS PRESCRIBED BY MY PHYSICIAN. I REALIZE THAT IN ORDER TO PROVIDE THE BEST POSSIBLE CARE, THERAPY AND SPORTS CENTER INC. MAY NEED TO CONTACT MY DOCTORS. IN GIVING MY CONSENT TO BE TREATED, I AM ALSO GIVING MY CONSENT FOR THERAPY AND SPORTS CENTER, INC TO CONTACT MY DOCTORS.

PATIENT'S SIGNATURE:_____DATE_____

PARENT/GUARDIAN:_____DATE_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT ON MEDICAL BENEFITS

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION, INCLUDING THE HISTORY OBTAINED, PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS TO MY DESIGNATED INSURANCE CARRIER. IN ADDITION, I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO THERAPY AND SPORTS CENTER, INC.

SIGNATURE: _____DATE_____

GUARANTEE OF PAYMENT

I UNDERSTAND THAT THERAPY AND SPORTS CENTER, INC. WILL FILE MY INSURANCE CLAIMS FOR ME WITH AN ASSIGNMENT OF BENEFITS. I AM RESPONSIBLE FOR ANY BALANCE NOT PAID TO YOU BY MY INSURANCE COMPANY WITHIN A REASONABLE LENGTH OF TIME. CO-PAYS ARE DUE AT THE TIME OF SERVICE. I ALSO AGREE THAT IN THE EVENT THAT THERAPY AND SPORTS CENTER INC. IS REQUIRED TO BRING ANY LEGAL ACTION AGAINST ME TO COLLECT PAYMENT FOR TREATMENT, I WILL BE RESPONSIBLE TO PAY ATTORNEY'S FEES AND COURT COSTS WHICH MAY BE INCURRED THEREIN.

SIGNATURE: _____DATE_____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY THERAPY AND SPORTS CENTER, INC. FOR THE PURPOSE OF PROVIDING TREATMENT TO ME, OBTAINING PAYMENT OF MY HEALTH CARE BILLS OR TO CONDUCT HEALTH OPERATIONS OF THERAPY AND SPORTS CENTER, INC. I UNDERSTAND THAT THE TREATMENT OF ME BY THERAPY AND SPORTS CENTER, INC.'S PROFESSIONAL STAFF MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY SIGNATURE BELOW. I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO HOW MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS OF THE PRACTICE. T&SC IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF T&SC AGREES TO A RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON T&SC AND THEIR STAFF. I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRIITNG, AT ANY TIME, EXCEPT TO THE EXTENT THAT THE PROFESSIONAL STAFF OF T&SC HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT. MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR A HEALTH CARE CLEARINGHOUSE. THIS PROTECTED INFORMATION RELATES TO MY PAST, PRESENT, AND FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND IDENTIFIES ME, OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME. I UNDERSTAND I HAVE THE RIGHT TO REVIEW T&SC'S NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THE NOTICE OF PRIVACY PRACTICES DESCRIBES THE TYPES OF USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT WILL OCCUR IN MY TREATMENT, PAYMENT OF MY BILLS, OR IN THE PERFORMANCE OF HEALTH CARE OPERATIONS OF T&SC. THE NOTICE OF PRIVACY PRACTICES FOR T&SC IS MADE AVAILABLE AT THE RECEPTIONIST'S DESK. THIS NOTICE ALSO DESCRIBES MY RIGHTS AND T&SC'S DUTIES WITH RESPECT TO MY PERSONAL INFORMATION. T&SC RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES BY CALLING THE OFFICE AND REQUESTING A REVISED COPY BE SENT TO ME IN THE MAIL.

SIGNATURE:_____DATE_____

WHO ELSE MAY THERAPY AND SPORTS CENTER, INC. DISCUSS YOUR MEDICAL OR BILLING INFORMATION WITH:

_____

THESE SIGNATURES WERE **WITNESSED** BY _____ DATE:_____

Therapy & Sports Center, Inc. Patient History Form

Name:_____ Date:_____

Referring Doctor:_____ Primary Care Doctor:_____

SOCIAL HISTORY:

What is your occupation:_____ Full Time Part Time Unemployed Self Employed

Retired Homemaker Student Off Work

Where do you live?: House Apartment/Condo Mobile Home Other:_____

Do you live alone: Yes No Do you need to speak with a social worker regarding your health or your care? Yes No

MEDICAL HISTORY: Height:_____ Weight:_____ Age:_____ Do you smoke: Yes No

In general how would you rate your overall health: Excellent Very Good Good Fair Poor

Do you have any allergies: Yes:_____ No

Condition	YES	NO
Asthma,bronchitis,or emphysema	_____	_____
Shortness of breath/ chest pain	_____	_____
Coronary heart disease/ Angina	_____	_____
Heart attack or heart surgery	_____	_____
Do you have a pacemaker?	_____	_____
High Blood Pressure	_____	_____
Stroke/TIA Date:_____	_____	_____
Blood Clot/ Emboli	_____	_____
Epilepsy/ Seizures	_____	_____
Anemia	_____	_____
Infectious Diseases	_____	_____
Diabetes	_____	_____
Cancer or chemotherapy	_____	_____
Arthritis/ Swollen joints	_____	_____
Osteoporosis	_____	_____
Severe/ frequent headaches	_____	_____
Vision/Hearing difficulties	_____	_____
Dizziness/ Fainting	_____	_____
Weight Loss/ Energy Loss	_____	_____
Hernia	_____	_____
Sleeping problems/ difficulties	_____	_____
Joint Replacements/ Implants	_____	_____
Shoulder Injury/Surgery	_____	_____
Elbow or Hand Injury/Surgery	_____	_____
Neck or Back Injury/Surgery	_____	_____
Knee Injury/Surgery	_____	_____
Leg or Ankle Injury/ Surgery	_____	_____
Are you pregnant?	_____	_____

Please list your current medications:

_____

_____

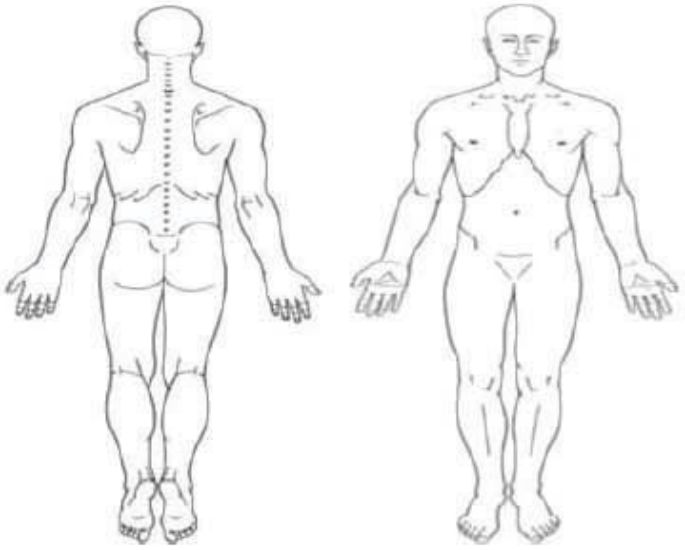
_____

_____

_____

_____

X for pain, = for numbness, * for tingling, # for burning



Rate the intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

CURRENT EPISODE: When did your symptoms/ this episode start:_____

Describe your symptoms:_____

How often do you experience your symptoms: Constantly Frequently Occasionally Rarely

How much have your symptoms interfered with your daily activities?: None A little bit Moderate Quite a bit Extreme

Have you had similar symptoms in the past: Yes No

Who did you see for your symptoms: No One Medical Doctor Chiropractor Physical Therapist Other:_____

What treatment did you receive: XRays MRI CT Scan Surgery Other:_____

What are your goals:_____

Sign:_____Date:_____