PATIENT INFORMATION – WORK RELATED INJURY

Please Print Date:____________________

PATIENT'S NAME____HOME PHONE:(____)______________________

ADDRESS:____DRIVERS LICENSE___________________________

CITY:___________________________STATE_______ZIPCODE_________E-mail address_________________________

JOB TITLE____LENGTH OF EMPLOYMENT___________________________

EMPLOYER____PHONE (___)_______________________________

EMPLOYER ADDRESS____

CITY_______________________________________STATE___________________ZIP CODE_____________________

DATE OF BIRTH______________________AGE__________SOCIAL SECURITY #_______________________________

SINGLE________MARRIED__________SEPARATED__________DIVORCED___________WIDOWED___________

IN CASE OF AN EMERGENCY - NEAREST RELATIVE NOT LIVING WITH YOU:

PERSON TO CONTACT__________________________RELATION___________PHONE (____)__________________

SPOUSE'S NAME____BUSINESS PHONE (____)_________________

DATE OF INJURY____

INSURANCE CO. RESPONSIBLE FOR PAYMENT:____

ADDRESS____PHONE (____)_____________

CITY____STATE____________________ZIP CODE_________________

ATTENTION_______________________________________CLAIM #____

LAWYER____PHONE(____)_________________________

ADDRESS____________________________CITY_____________________STATE________ZIPCODE______________

HAVE YOU BEEN A PATIENT AT SPORTHO PHYSICAL THERAPY BEFORE? YES_____/ YR_____ NO_________

REGARDING APPOINTMENTS: IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, PLEASE NOTIFY US AT LEAST 1 TO 2 HOURS BEFORE YOUR SCHEDULED SESSION. THIS ALLOWS ANOTHER PATIENT TO USE THE TIME WHICH HAD BEEN SET ASIDE FOR YOU. FAILURE TO LET US KNOW OF YOUR CANCELLATION WILL RESULT IN A $40.00 CHARGE TO YOU. IT IS NECESSARY TO RESCHEDULE YOUR MISSED APPOINTMENT.

FAMILY PHYSICIAN_________________________
ADDRESS:___________________________________
PHONE (   )________________________________

____
PATIENT'S SIGNATURE

**** HOW DID YOU HEAR ABOUT SPORTHO?____
****

VERIFIED____________________

NAME_______________________ ACCOUNT #__________________________

DATE________________________ M.D_____________________________________ NEXT M.D. APPT_________________________

SPORTHO
PHYSICAL AND
AQUATIC THERAPY

Patient Medical History Form

Name: ______________________________ **Date of Birth:** ______________

Past/Present Medical History: (please check all that apply)

high blood pressure ___	pacemaker ___	exposure/treatment TB (or any
heart condition ___	seizures ___	other infectious disease) ___
stroke ___	cancer ___	fever for > 2 weeks ___
unexplained weight loss ___	diabetes ___	do you smoke ___

Other (please explain) ____

____

Past hospitalizations/surgeries ____

____

Past orthopedic problems ____

____

Are you currently taking medications? (please list) _________________________

____

Current Orthopedic problem:

What brings you to Sportho today? ____

____

Have you had any past treatment for this condition? __________________________

____

Have you received any special test related to your condition? (e.g.:CT scan, MRI) ________

____

What activities/position makes your condition worse? _________________________

What activities/position makes your condition better? ________________________

If pain is your primary complaint, please rate it on a 0-10 scale (O being no pain):

at your best ____ at your worst ____

Work/Play History:

Job Title: ___________________________ Last day worked: __________________

Brief job description (physical demands): ____________________________________

____

Has this condition resulted in an absence from work and/or modified duty? ______________

What is the most difficult task for you to perform on your job secondary to your condition? _

____

What type of exercise/activities do you perform on a regular basis? ____________________

Are you still able to perform these activities?__________________________________

What are your goals in therapy? ____

____

Patient/guardian signature: ______________________________ **Date:** ________

Therapist signature: ____________________________________ **Date:** ________

WORKER COMPENSATION
FINANCIAL POLICY

PAYMENT OF FEES: Workers' Compensation is a contract between you and your company. We will verify your claim and secure the necessary authorizations to assure payment. We will bill the insurance carrier on your behalf and cooperate with you, your company and the insurance carrier to expedite payment of **your** claims. If Workers' Compensation is denied, you will be responsible for all balances as treatment was provided to you.

APPOINTMENTS: Patients are seen by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments in weekly intervals.

Your promptness for appointments is necessary as sessions start as scheduled. In the event you need to cancel an appointment, we request notice of this, as soon as, possible to allow another patient to use the time that had been set aside for your visit. Failure to cancel your appointment will result in a $50.00 charge directly to you. Please note that this is not covered by Workers' Compensation.

I acknowledge that I have read the above and understand the contents of it. I agree to be bound by the terms contained herein.

I assume full responsibility for payment of services and agree to pay them in full if denied by Workers' Compensation.

Sportho Physical and Aquatic Therapy, Ltd. is authorized to supply information necessary to secure payment from the Workers' Compensation carrier and to discuss treatment with the appropriate case managers servicing my claim.

DATE:_____________ PATIENT'S SIGNATURE____________________________________