swing orthopedic
SPORTS PHYSICAL THERAPY

Last Revision Date: 04/07/2015

New Patient Paperwork

PATIENT INFORMATION				
PATIENT NAME Last	First	M.I.	PREFERED NAME	
ADDRESS Street	City	State	Zip	
ADDRESS 2 Street	City	State	Zip	
PRIMARY PHONE #	SECONDARY PHONE #			
DATE OF BIRTH / /	SOCIAL SECURITY #	SEX ☐ Male ☐ Female		
EMAIL ADDRESS	MARTIAL STATUS ☐ Minor ☐ Single ☐ Divorced ☐ Married ☐ Widowed			
EMPLOYER	WORK PHONE #			
EMERGENCY CONTACT	EMERGENCY CONTACT #			

RESPONSIBLE PARTY/ INSURANCE INFORMATION	
PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE NAME	INSURANCE NAME
INSURANCE ID #	INSURANCE ID #
ADDRESS	ADDRESS
NAME OF PRIMARY INSURED	NAME OF PRIMARY INSURED
DATE OF BIRTH	DATE OF BIRTH
SOCIAL SECURITY #	SOCIAL SECURITY #
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
PHONE #	PHONE #

WORKERS' COMPENSATION	
WORK RELATED INJURY? ☐ NO ☐ YES	DATE OF INJURY
EMPLOYER	WC CARRIER
EMPLOYER ADDRESS	WC CARRIER ADDRESS
CONTACT NAME	CONTACT NAME
EMPLOYER PHONE #	CONTACT PHONE #

MOTOR VECHILE ACCIDENT		
MOTOR VEHICLE ACCIDENT RELATED INJURY? ☐ NO ☐ YES	If yes, please notify front office staff once paperwork is completed.	

REFERRAL INFORMATION	
NAME OF REFERRING PHYSICIAN	If not a medical provider, whom may we thank for referring you?

I confirm that the above given information is correct and true to the best of my knowledge:

Patient/Legal Guardian _____
Print Name

Patient/Legal Guardian _____ Date
Signature

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Medical Screening Form

Height: _____ Weight: _____

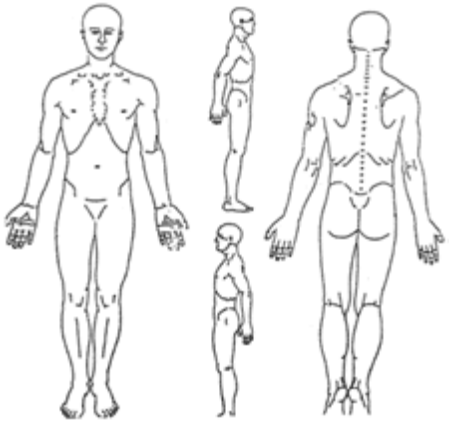
Health History								
Asthma	Y	N	Fever/chills/sweat	Y	N	Pacemaker	Y	N
Blood disorders	Y	N	Headaches	Y	N	Seizures	Y	N
Bowel/Bladder Issues	Y	N	Heart Conditions	Y	N	Shortness of breath	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Changes in appetite	Y	N	Lung Problems	Y	N	Rheumatoid arthritis	Y	N
Chest pains	Y	N	Numbness/tingling	Y	N	Weight changes	Y	N
Depression	Y	N	Osteoarthritis	Y	N	Other:		
Diabetes	Y	N	Osteoporosis	Y	N			
Dizziness	Y	N	Pregnant	Y	N			

Past Injuries/Surgeries			Injury/Surgery Date	Description
Heart/Lung Surgery	Y	N		
Spinal Surgery	Y	N		
Joint Replacements	Y	N		
Fractures	Y	N		
Other	Y	N		

Current Medications		
Pain	Cardiac conditions	Other: List below
Muscle relaxants	Blood pressure/cholesterol	
Anti-inflammatories	Diabetes	

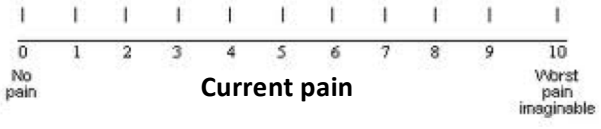
Occupation and Job Duties
Exercise/Activities

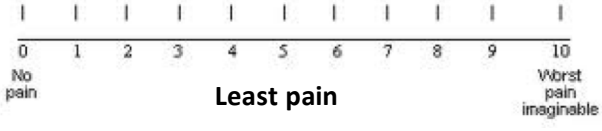
What is your primary complaint today?

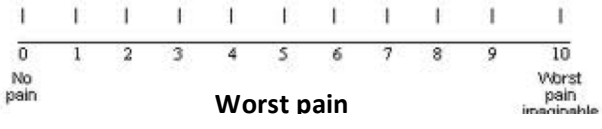


Please place an "X" over current symptom areas

On a scale from 0-10, rate your pain for the past 24 hours.







Patient/Legal Guardian Signature_____Date_____

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Consent for Treatment

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Swing Orthopedic Sports Physical Therapy.

I understand that the physical therapist will fully explain to me the nature and purposes of the procedures of physical therapy during the initial evaluation and throughout the course of my treatment. The physical therapist will inform me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist will explain to me the risks of receiving no treatment.

I acknowledge that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain, discomfort, or aggravate my condition. I recognize that questions regarding my physical therapy care should be addressed with the physical therapist and be answered in a satisfactory manner throughout the duration of my treatment.

I confirm that I have read and fully understand this consent form. By signing the below, I consent to treatment at Swing Orthopedic Sports Physical Therapy and agree to abide by the conditions stated above.

Patient/Legal Guardian Signature_____Date_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance companies and third-party payers.
- Conduct normal healthcare operations such as physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Swing Orthopedic Sports Physical Therapy, Inc. at any time at the above address to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient/Legal Guardian Signature_____Date_____

I hereby permit; Swing Orthopedic Sports Physical Therapy may disclose my protected medical information to the following individuals:

Name_____Relationship_____

Name_____Retationship_____

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Financial Policy

Swing Orthopedic Sports Physical Therapy appreciates the confidence you have shown in choosing us to provide for your health care needs.

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. Please contact your insurance company to verify coverage of our services. **As a courtesy, we will verify your primary insurance coverage** and bill your insurance carrier on your behalf. Please understand that when verification of benefits occurs, insurance companies do not guarantee payment of medical benefits. The information received from the insurance company at the time of verification can only be used as an estimate of payment for services. We allow 60 days for your insurance company to pay. After which time the remaining unpaid balance in due to payable by the patient.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect the co- payments, co-insurances, and payments toward the deductible of your insurance plan, as communicated by our staff, to be paid at time of service. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. Accrued, unpaid balances reaching $100 or more will require payment on behalf of the patient or responsible party for continuation of services. If payment cannot be provided due to financial hardship, a payment plan form must be completed.

CANCELLATION/ NO SHOW POLICY
We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancel your appointment. No show may result in a $15.00 fee, which will not be paid by your insurance company.

RETURNED CHECKS /OVER DUE ACCOUNTS
There is a $10.00 service fee on all returned checks. Accounts passed due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.

SELF-PAY
If you do not have insurance coverage or if you prefer to file your own insurance, you are expected to pay all charges in full at time of service.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

Patient/Legal Guardian Signature_____Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, Consent to Treat and/or Financial Policy, but was unable to do so as documented below:

Date _____ Initials _____

Reason_____