

PATIENT INFORMATION

LAST NAME:		FIRST:	MIDDLE:	BIRTHDATE: / /	AGE:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
CURRENT ADDRESS:				SOCIAL SECURITY:	HOME PHONE: ()	
CITY:	STATE:	ZIP CODE:	BILLING ADDRESS (if different):			
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER			SPOUSE'S NAME:			
OCCUPATION:			EMPLOYER/SCHOOL NAME:		EMPLOYER PHONE: ()	

REFERRING PHYSICIAN INFORMATION

DOCTOR'S NAME:	PHONE NUMBER: ()	ADDRESS/CLINIC NAME:
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REASON FOR TODAY'S VISIT

BODY PART/HOW INJURY OCCURRED:	
IS THIS INJURY/CONDITION RELATED TO <input type="checkbox"/> WORK <input type="checkbox"/> CAR <input type="checkbox"/> HOME <input type="checkbox"/> OTHER: _____	DATE OF INJURY / 1ST SYMPTOM:

IF PATIENT IS A MINOR

NAME OF GUARANTOR:	BIRTHDATE / /	RELATIONSHIP
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EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

NAME (Last, First, Middle):	RELATIONSHIP:	HOME PHONE: ()	DAY PHONE: ()
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RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and health care institutions as is necessary to my care and treatment. By signing below, I agree to consent to care by Proliance Sports Therapy.

SIGNATURE OF PATIENT/GUARDIAN

DATE:

Patient Financial Responsibilities

Proliance Sports Therapy and Rehabilitation, a division of Proliance Surgeons, is committed to providing you with the highest-quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance Sports Therapy and Rehabilitation.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card, and Social Security number to enable us to submit your claims promptly and accurately.
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours' advance notice should you need to cancel or reschedule an appointment.

Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over \$100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance: Please be prepared to pay for your portion of the charges on the date of service.

Non-Participating Insurance: If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and will be immediately due and payable.

Uninsured Patients

Visits: Visits must be paid in full at the time of service. In return, we offer you a 20% discount. This discount does not apply in cases of motor vehicle accidents, third-party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third-Party Patients:

We do not extend discounts for MVA-insured accidents, third-party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation:

If your visit is work related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, you may be required to pay a deposit at time of service.

Other Charges

No Show: Please provide us with at least 24 hours' advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours' advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms: There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options: We accept checks and all major credit/debit cards and money orders for payment (no post-dated or third-party checks). We charge a \$40.00 NSF fee for any returned checks.

Delinquent Accounts: We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements: If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past-due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt: Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care may be required to pay for their portion of new charges at the time of service.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of patient

Relationship (parent, personal representative, etc.)

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

Signature of Patient or Guardian

Date

Time

Printed Name

**AUTHORIZATION TO LEAVE PERSONAL INFORMATION
BY ALTERNATE MEANS**

Patient Name: _____ Date of Birth: _____

Please check all that apply:

- May leave detailed message on voicemail at home # _____
- May leave detailed message on voicemail at work # _____
- May leave detailed message on my cellular phone # _____
- May leave detailed message at different location # _____
- May leave detailed message with spouse (Name) _____
- May leave detailed message with other family member (Name) _____
- May send detailed message by e-mail to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or Legally Authorized Individual Signature

Date

MEDICAL INTAKE / PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/____

Area of Injury: _____ Side of body: L R Hand Dominance: L R

Date of Injury: _____ Date of Surgery: _____

How did the Injury Occur: _____

Briefly describe your symptoms (what makes it better / worse, what it prohibits you from doing, etc.)

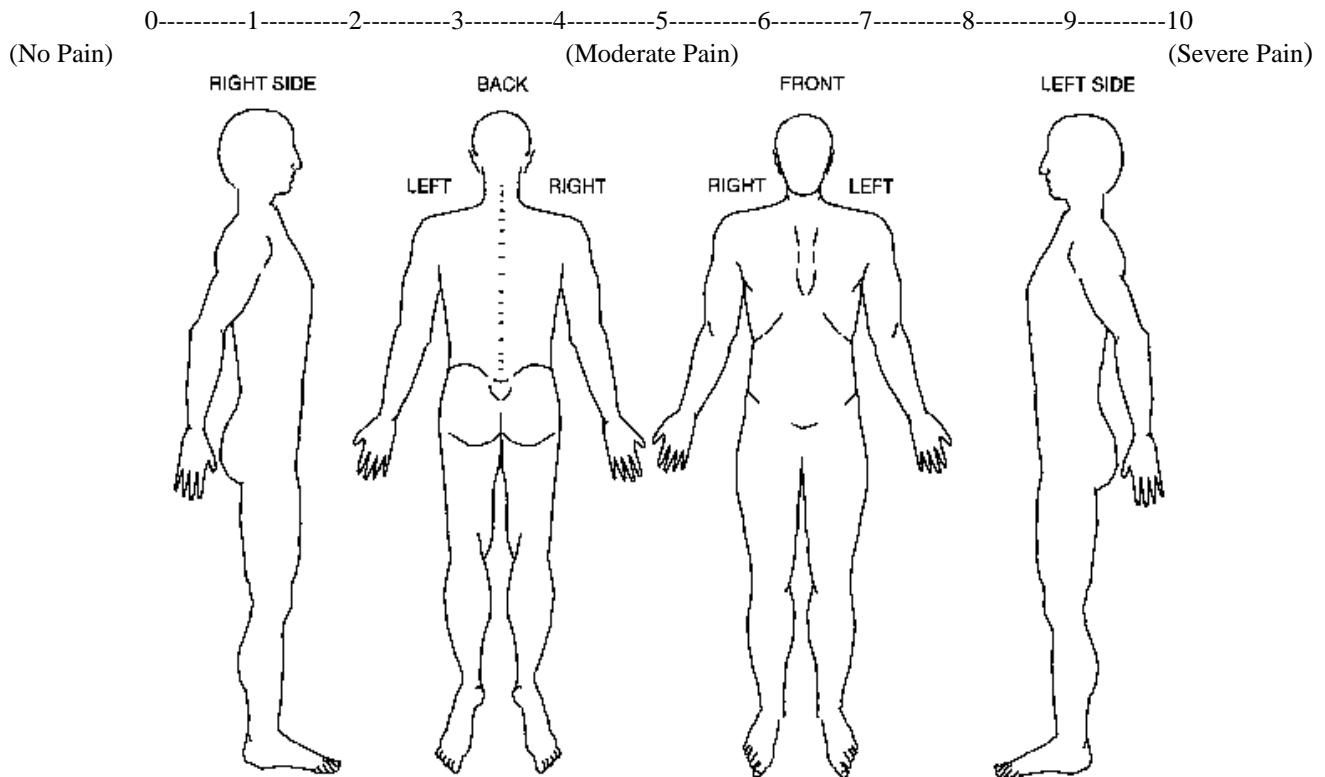
Have you ever had physical/occupational therapy or other treatment for this problem? (chiropractic, acupuncture, braces/splints, etc.) If yes, please describe:

Relevant operative or invasive procedures and/or injuries:

Diagnostic Testing: X-Ray CT Scan EMG MRI

Results (if known): _____

Please rate your pain level on a scale from 0 to 10. Circle the appropriate number. Use the diagram to circle any problem areas where you have experienced pain in the last week.



Please indicate if you have, or have ever had, the following conditions:

- | | | |
|-----------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> DVT (Blood Clots) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> AIDs/HIV | |

Do you have any metal implants or artificial joints? Yes No

Are you currently taking steroid medication? Yes No

Are you a smoker? Yes No

Are you or could you be pregnant? Yes No

Are you currently employed? Yes No

What is your works status? Full Duty Light Duty Out of Work
 Student Retired Disability
 Restrictions Part Time Other

What are your job duties/responsibilities? _____

Please list your current medications: _____

Allergies: _____

What are your personal goals during physical therapy? (e.g., return to work, resume a recreational activity, dress yourself, negotiate stairs, etc.)

Date of the next physician's visit: _____

Patient Signature: _____

Date: _____

Therapist Signature: _____

Date: _____