RETURN TO SPORT
PHYSICAL THERAPY

Patient Name: Last_____ First_____ M.I.____

Date of Birth: _____ Age_____ Male or Female (circle one)

Home Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Phone # mobile: _____Home: _____ Work: _____

In case of emergency whom may we call? _____ Phone: _____

Name of referring physician or physician you would like us to send our Physical Therapy evaluation to: _____

How did you hear about us? _____

Primary Insurance Company:

Policy #_____ Group #_____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Secondary Insurance Company:

Policy #_____ Group #_____ Effective Date: _____

Subscriber Name: _____ Relationship to patient: _____ DOB: _____

Assignment of Benefits/Release of Information:

I hereby authorize Return to Sport Physical Therapy to perform all treatments and procedures that they consider necessary for my benefit, upon consultation with my representative or myself. I understand that I am financially responsible for any balances not covered by my insurance. I understand that there may be a $50 no show/cancellation charge if I fail to show up or call 24hours in advance.

Medicare Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made on my behalf to Return to Sport Physical Therapy.

Insurance Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under the provisions of my medical insurance is correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Return to Sport Physical Therapy.

_____ _____

PATIENT SIGNATURE or AUTHORIZED REPRESENTATIVE DATE

NOTICE OF PRIVACY PRACTICES

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act (HIPPA) of 1996 along with a brief overview of our new Notice of Privacy. Our practice is complying with HIPPA's regulations.

What is HIPPA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to health care. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your own medical records, allowed control over how your protected health information is used and disclosed and allowed to take action of your privacy is compromised by following the practice's policy. Out practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable health information (IIHI)?

Any health information you provide, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual. What is the Notice of Privacy Practice? Our practice has an official Notice of Privacy Practice posted in our treatment areas informing our patients about their rights surrounding the protection of you IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our treatment areas and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

- Treatment
- Appointment Reminders
- Release of information to family/friends
- Payment
- Treatment Options
- Disclosures Required by Law
- Healthcare Operations
- Health related benefits and services

The following categories describe unique situations in which we may use or disclose your identifiable health information:

- Public risks
- Health oversight activities
- Lawsuits
- Law enforcement
- Deceased patients' organs and tissue donation
- Research
- Serious health threats/safety

What are your rights concerning your individually Identifiable Health Information (IIHI)?
You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communication
2. Requesting restrictions
3. Inspection and copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide and authorization for other uses

If you have any questions regarding this notice or our health information privacy policies, please contact **Return to Sport Physical Therapy, SC**

Acknowledgement of Receipt of Notice of Privacy Practices

I have read the Notice of Privacy Practices from Return to Sport Physical Therapy.

X _____ Date: _____

Staff member of Return to Sport Physical Therapy.

X _____ Date: _____

HEALTH HISTORY

Name: _____ DOB: _____ Date: _____

Please answer the following questions:

What injury or condition brings you here today? _____

How did this injury happen and when did it star? _____

_____

Are you seeing (or have you been seen) by any other health professionals for your current condition? Please list:

_____

What tests have you had for this condition? _____

How would you describe your symptoms? _____

What makes your symptoms better? _____

What are you unable to do because of your pain/problems? _____

Have you had any major surgeries? If so please list with approximate dates: _____

Have you been treated for any conditions in the past year? _____

Allergies/Reactions? _____

Medications?

_____

Please list any other medical history:

HEALTH HISTORY

Please circle yes or no for each of the following conditions:

Do you have cardiac problems?	YES	NO
Do you have a cardiac pacemaker?	YES	NO
Do you have high blood pressure?	YES	NO
Do you have a metal implant?	YES	NO
Do you have a joint replacement?	YES	NO
Do you have a history of cancer?	YES	NO
Do you have shortness of breath?	YES	NO
Do you have angina (chest pain)?	YES	NO
Do you have diabetes?	YES	NO
Do you smoke?	YES	NO
Do you have lung disease?	YES	NO
Do you have a history of seizures?	YES	NO
Do you have a history of high cholesterol?	YES	NO
Do you have balance issues?	YES	NO
Do you have a history of fractures?	YES	NO
Are you pregnant?	YES	NO

The purpose of this questionnaire is to assist us with providing you quality care by obtaining a better understanding of your total health status. We appreciate your completion of this questionnaire. Should you have any questions or need to share additional information, please discuss with your therapist. This questionnaire along with all health discussions is considered part of your confidential medical record.

Signature: _____ Date: _____