D&D SPORTS MED
DENTON • SANGER • AUBREY

D&D Sports Med

___ Denton ___ Sanger ___ Aubrey

Patient Information
Medicare Patient

Patient Registration Information

Name: (First) (MI) (Last)	Social Security #:	
Date of Birth:	Address:	
Home Phone:	City:	State: Zip:
Cell Phone:	Email Address:	
Sex: Male Female	Marital Status: Single Married Other: _____	

Insured Party/Responsible Party Information

Relationship to Patient:	Social Security #:	
Name: (First) (MI) (Last)	Date of Birth:	
Address:	City:	State: Zip:
Home Phone:	Work Phone:	
Sex: Male Female	Marital Status: Single Married Other: _____	

Patient's Employer Information / Insured's Employer Information

Employer:			Employer:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Injury Information

Date of Injury:	Description of Injury/How did injury occur?
Injury occurred: Work Auto accident Other: _____	

Emergency Contact Information

Emergency Contact: Phone #:

Relationship to patient:

How did you hear about us? Physician Friend/Family Phonebook Walk-In
Website Other: _____

Patient/Guardian Signature

I certify that the information provided above is true.

Patient/Guardian Signature: Date:

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D&D Sports Med
Medicare Patient Information

Have you had any physical therapy, occupational therapy, speech therapy, or chiropractic care since the beginning of this calendar year? Yes _____ No _____
If yes, approximate dates: _____ Where?_____

Have you received **any type** of Home Health Care in the last calendar year? Yes _____ No _____
If yes, with what agency? _____When were you discharged? _____

Have you been in a skilled nursing inpatient facility in the last calendar year? Yes _____ No _____
If yes, with what facility? _____When were you discharged? _____

Have you been admitted to a hospital in the last calendar year? Yes _____ No _____
If yes, with what facility? _____When were you discharged? _____

Do you have Medigap insurance? Yes _____ No _____

Is your present illness/injury resulting from a motor vehicle accident? Yes _____ No _____
If yes, please provide the following: date & time of accident: _____

Is the accident work related? Yes _____ No _____
If yes, are you covered by Workers Comp? Yes _____ No _____

Was the injury caused by other type of accident? Yes _____ No _____
If yes, please explain: _____
Name of owner of the property where accident occurred: _____

If applicable, please complete the following:
Name & address of auto insurance: Name & address of liability insurance

_____ _____
_____ _____

Name & address of any attorneys you have retained: _____

Are you currently employed? Yes _____ No _____

Is your spouse currently employed? Yes ____ No _____

Does your spouse cover you under his/her policy? Yes _____ No _____

Are you disabled and under age 65? Yes _____ No _____

Are you covered under the veteran's administration? Yes _____ No _____

Are you covered by Medicare under black lung? Yes _____ No _____

_____ _____ _____
Patient's Signature Date Guardian Sig. if applicable

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D&D Sports Med
Medical History Form

Patient's Name: _____ Patient's Age: _____

Describe the current symptoms for which you are seeking therapy: _____

Date of Injury/onset of condition: _____

Have you ever experienced these symptoms before? Yes (When) _____ No _____

Describe your symptoms (check all that apply):

_____ Pain	_____ Loss of strength	_____ Better with activity
_____ Ache	_____ Loss of motion	_____ Constant pain
_____ Balance Loss	_____ Worse in AM	_____ Night pain
_____ Numbness/Tingling	_____ Worse in PM	_____ Other: _____

Please rate your pain from 0-10 (0= no pain; 10 = emergency room pain)
Current = _____ Best = _____ when I _____ Worst = _____ when I _____

List 3 things you are unable to do as a result of your condition:
1. _____
2. _____
3. _____

What activities increase your symptoms? (Check all that apply)

_____ Sitting	_____ Standing	_____ Rising from chair	_____ Reaching overhead
_____ Walking	_____ Bending	_____ Sleeping	_____ Rolling over in bed
_____ Cooking	_____ Grasping	_____ Writing	_____ Lying on side
_____ Driving	_____ Running	_____ Throwing	_____ Cough/sneeze/strain
_____ Stairs	_____ Dressing	_____ Housework	_____ Computer work
_____ Other: _____			

Please indicate if you are currently experiencing any of the following (Check all that apply):

_____Dizziness	_____ Vision problems	_____ Hearing Loss	_____ Fever/sweats/chills
_____ Malaise	_____ Weakness	_____ Nausea/vomiting	_____ Night pain
_____ Changes in urinary/bowel frequency			

Tests and Results:

1.	X-Rays	YES	NO	Results: _____	Date: _____
2.	MRI	YES	NO	Results: _____	Date: _____
3.	CT Scan	YES	NO	Results: _____	Date: _____
4.	EMG	YES	NO	Results: _____	Date: _____
5.	Other: _____			Results: _____	Date: _____

Have you had surgery related to this condition? Yes _____ No _____

If yes, type of surgery: _____ Date of surgery: _____

Work History:

Are you presently working: Yes No If no, how many total days of work have you missed? _____

Are your work duties? Full Restricted How many hours per week do you work? _____

Who is your employer? _____ What type of work do you do? _____

What critical work duties have been most affected by your injury/condition? _____

_____

Please Indicate how you sustained this condition:

_____ Work related injury
_____ Cause unknown
_____ Motor Vehicle Accident
_____ Athletic/Recreation Injury
_____ Recurrence of prior condition
_____ Injury related to lifting
_____ Chronic
_____ OTHER: _____

Please list any other surgeries you have had, including type and date: _____

_____

_____

Have you had any physical therapy, occupational therapy, or chiropractic care since the beginning of this calendar year (including home health)? Yes _____ No _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Diabetes	Self _____	Family_____	Allergies: _____	Self _____	Family_____
Chest Pain/Angina	Self _____	Family_____	Thyroid Problems	Self _____	Family_____
Heart Disease	Self _____	Family_____	Osteoporosis/Osteopenia	Self _____	Family_____
High Blood Pressure	Self _____	Family_____	Arthritis	Self _____	Family_____
Heart Attack	Self _____	Family_____	Metal Implants	Self _____	Family_____
Pacemaker	Self _____	Family_____	Recent Fractures	Self _____	Family_____
Vascular Disease	Self _____	Family_____	Hernia	Self _____	Family_____
CVA/Stroke/TIA	Self _____	Family_____	Infectious Disease	Self _____	Family_____
Seizures	Self _____	Family_____	Dizziness/Fainting	Self _____	Family_____
Headaches	Self _____	Family_____	Nausea/Vomiting	Self _____	Family_____
Kidney Problems	Self _____	Family_____	Skin Abnormalities	Self _____	Family_____
Cancer: _____	Self _____	Family_____	Sexual Dysfunction	Self _____	Family_____
Bowel/Bladder Problems	Self _____	Family_____	Ringing in your Ears	Self _____	Family_____
Asthma	Self _____	Family_____	Depression	Self _____	Family_____
Liver/Gallbladder Problems	Self _____	Family_____	Anxiety	Self _____	Family_____
Special Dietary Guidelines	Self _____	Family_____	Do you use tobacco?	Self _____	Family_____
Are you Pregnant?	Yes _____	No _____	If Yes. How long have you used tobacco? _____		
Fibromyalgia	Self _____	Family_____	Average weekly usage: _____		
Concussion	Self _____				

If you answered "yes" to any of the above, please explain and give approximate dates: _____

_____

_____

Do you participate in any sports, exercise program, or activities on a regular basis? Yes _____ No _____

If yes, please describe: _____

Is there any other information regarding your past medical history that we should know about?_____

_____

_____

Have you experienced any falls in the last 12 months? Yes _____ No _____ If yes, how many? _____

Have you been injured from a fall during the last 12 months ? Yes _____ No _____

When are you scheduled to see your doctor again? _____

FOR OFFICE USE:

Clinician's Initials: _____

Today's Date: _____

To the best of my knowledge and belief, the information I have given above is accurate and true.

_____ _____ _____

Patient's Signature | Today's Date | Parent/Guardian Signature if applicable

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Medications

In order to gain a more comprehensive view of your condition, we need to know what medications you are taking. This includes **prescription medications, over-the-counter medications, vitamins, and any other supplements**. Please complete the form below and bring it with you to your first appointment. (You may bring a different list, but it MUST include all of the required information)

Name of Medication (Name of drug on package)	Dosage (usually in mg. or ounces, etc.)	Frequency (Daily, 2 X day, etc.)	Route of Administration (Orally, injection, etc.)	Changes or Comments
EXAMPLE: Coumadin	3 mg.	Daily	Orally	BIW as of 1/15/14

I attest that the above information is correct and true to the best of my ability. I acknowledge that I should inform my therapist of any changes that occur in my medication while a patient at D&D.

Patient's Printed Name

Patient's Signature

Today's Date

Therapist's Signature/Date

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PATIENT INFORMATION CONSENT FORM

I have been provided with a copy of ***D&D Sports Med*** 's Notice of Information Practices. I understand that ***D&D Sports Med*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that D&D Sports Med's PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***D&D Sports Med***'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I hereby consent to the release of personal health information (verbal or written) regarding my treatment and/or account information for services rendered at D&D Sports Med to the following individual(s):

_____ Person's Name	_____ Relationship to you
_____ Person's Name	_____ Relationship to you
_____ Person's Name	_____ Relationship to you
_____ My signature	_____ Today's Date

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Medicare Benefits Acknowledgment

As a Medicare patient, I am aware that I have a $185.00 deductible for 2019 that must be met prior to Medicare initiating payments.

I am also aware that Medicare pays 80% of their contracted rate and that I am responsible for the remaining 20%. D&D Sports Med has agreed to file on any secondary insurance I may have, but depending on my secondary coverage, a balance may remain after my secondary insurance processes the claims.

I am aware of these financial responsibilities, and agree to pay for these services as outlined in the Medicare fee guidelines should a balance remain.

_____ _____

Patient's signature Today's date

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D&D Sports Med
Financial Policy

Thank you for choosing D&D Sports Med as your Physical/Occupational Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.
Payment for services is due prior to or upon completion of each treatment visit. We accept CASH, MASTERCARD, VISA, AMERICAN EXPRESS, or PERSONAL CHECKS. Once your complete insurance information is on file, we will happy to submit your claims to your insurance company. _____ **INITIALS**

REGARDING PRIVATE INSURANCE:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered. Unpaid balances are subject to 10% interest, accrued monthly.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee provided by the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment. If an overpayment from you is discovered, you will be refunded once all claims for all dates of service are processed. There is a $5.00 fee for re-processing an un-deposited refund check as long as it is dated with a year from the request. Any un-deposited refund checks that are more than a year old will not be reprocessed.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make the proper adjustments to your claim. _____ **INITIALS**

NON-COVERED EXPENSES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses. _____ **INITIALS**

MISSED APPOINTMENTS

Please notify us within 24 hours in advance to cancel your appointment. Failure to notify us within 24 hours (48 hours over a weekend) or no-showing for an appointment may result in a $30.00 cancellation fee. It is our policy to reschedule any cancelled appointments at the time of your call. Attending your scheduled appointments is crucial to successful treatment and recovery from your injury. _____ **INITIALS**

INFORMATION

I give permission to D&D Sports Med to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize D&D Sports Med to obtain medical records from my physician or other medical professionals as it relates to my treatment.

_____ **INITIALS**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment.

_____	_____
Patient's Signature	Parent/Guardian Signature
_____	_____
Witness' Signature	Date of signatures