

SPORT AND SPINE THERAPY OF MARIN220 Greenfield Ave.
San Anselmo, CA 94960Ph (415)457-4454
Fax (415)457-4944**NEW PATIENT FORM**

EVAL DATE: _____

Patient Information	Last Name	First Name	M.I.
	Mailing Address	Home Phone ()	Other Phone ()
	City State ZIP	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Social Security Number
	Date Of Birth	Age Sex	Email Address
	Employer	Employer Address & Telephone # ()	
	REFERRING PHYSICIAN:		PHONE NUMBER: ()
Guarantor	Guarantor Name (If patient is a minor)	Social Security Number	Occupation
	Address	Home Phone # ()	Employer
	City State Zip	Work / Alternate Phone # ()	Relationship To Patient
Emergency Contact	Name	Address	
	Relationship To Patient	Home Phone # ()	Work / Alternate Phone # ()
Primary Insurance	Primary Insurance	Subscribers Date of Birth	ID Number
	Subscribers Name	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian	Subscribers SSN
Secondary Insurance	I AM <input type="checkbox"/> I AM NOT <input type="checkbox"/> COVERED BY A SECONDARY INSURANCE CO. <input type="checkbox"/> <input type="checkbox"/>		
	Secondary Insurance	Subscribers Date of Birth	ID Number
	Subscribers Name	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian	Subscriber SSN
Worker's Comp	IS THIS A WORKER'S COMP CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO		Date Of Injury
	Insurance Company To Bill		Claim Number
	Adjuster	Adjuster Phone # ()	
Auto Accident	IS THIS AN AUTO ACCIDENT CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		Date Of Injury
	Insurance Company To Bill		Claim Number
	Adjuster	Adjuster Phone # ()	

Patient / Guardian Signature_____
Date

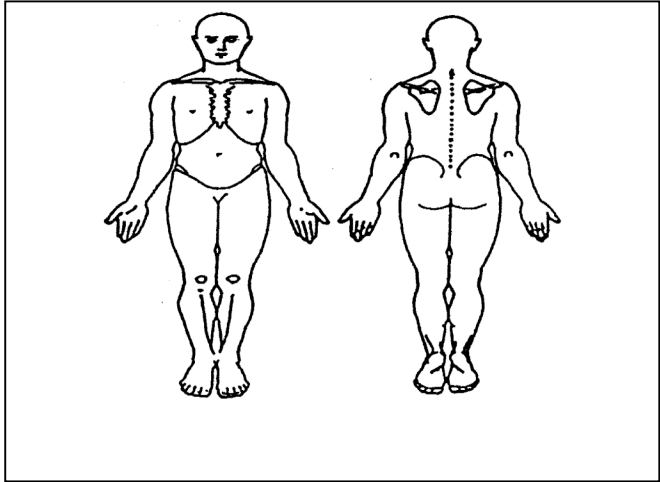
Sport and Spine Therapy of Marin, Inc

Patient Name _____ Age _____

Type of Injury / Condition _____ Onset / Injury Date _____

Type of Surgery & Date _____

Describe previous treatment for this condition _____



Have you received physical therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed:

- X-Ray
- MRI
- CT Scan
- Doppler
- Ultrasound

Have you recently noted:

- Weight Loss /Gain
- Weakness
- Pregnant / IUD
- Pain At Night
- Nausea / Vomiting
- Fever / Chills / Sweats
- Headaches
- Cramps In Legs When Walking
- Fatigue
- Numbness / Tingling
- Change In Vision Or Hearing
- Insomnia

Do you have now or have you ever had any of the following?

- Surgeries
- Sprains / Strains
- Heart Problems
- Circulation Problems / Clots
- Easy Bruising / Bleeding
- Indigestion / Heartburn
- Any previous injury that may affect current care: _____
- Loss of Consciousness
- Diabetes
- Cancer
- Asthma / Breathing Problems
- Leg / Ankle Swelling
- Fainting
- Fractures
- Blood Pressure Problems
- Motor Vehicle Accident
- Lung Disease
- Urinary Problems / Infections
- Allergies / Skin Sensitivity

Please give approximate date if you answer yes below:

Have you fallen two or more times in the last 12 months? Y N What months? _____

Did any of these falls result in an injury? Please explain: _____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

What are your physical or fitness goals: _____

Is there anything else you would like to include or ask your physical therapist? _____

Patient or Personal Representative Signature

Date

Sport and Spine Therapy of Marin, Inc

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Sport and Spine Therapy of Marin, Inc** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

AUTHORIZATION TO CONTACT: I authorize **Sport and Spine Therapy of Marin, Inc** to use my protected health information for **sending reminders, birthday wishes, notice of clinic events, and general therapy information**. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing.

YES NO

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Sport and Spine Therapy of Marin, Inc** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$40 for physical therapy visits and the full price of a massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Sport and Spine Therapy of Marin, Inc** to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature _____ Date _____

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Arrangements for payment of patient's co-pay/deductible **(circle one):**

Will pay each visit

Will pay weekly in advance

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature

Date