Patient Information

Last Name ____________ First Name ____________ MI ______ SSN ____________
Address ____________ City ____________ State ______ Zip ____________
Home Phone ____________ Work Phone ____________ Cell Phone ____________
Cell Phone Carrier ____________
Date of Birth ____________ Gender ________ Marital Status ________ Email ____________

Guarantor Information

Last name ____________ First Name ____________ Relationship ____________
Address ____________ City ____________ State ________ Zip ________
Home Phone ____________ Work Phone ____________ Cell Phone ____________

Patient/Guarantor's Employer

Name ____________ Phone ____________
Address ____________ City ____________ State ______ Zip ________

Emergency Contact

Last Name ____________ First Name ____________ Relationship ____________ Phone ________
Problem Description ____________ Date of Injury or Onset of Symptoms ________

Please circle one of the following- Type of accident: None Other Work Auto

If Motor Vehicle Accident list the state the accident occurred in: ____________

Details of Accident: ____________

Primary Insurance

Insurance ____________ ID ____________
Group # ________ Co-Pay ______ Co-Insurance ________

Subscriber
Name ____________
Relationship ____________
Date of Birth ____________

Secondary Insurance

Insurance ____________ ID ____________
Group # ________ Co-Pay ______ Co-Insurance ________

Subscriber
Name ____________
Relationship ____________
Date of Birth ____________

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Financial Policy.
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: ____________ **Date:** ____________

Minors under the age of 18 need to be accompanied at their first visit by a parent or guardian to sign patient information and financial responsibility forms. The parent of the guardian is responsible for full payment. If the parents are separated and both legally responsible for the child you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Signature: ____________ **Date:** ____________

How did you find our clinic?

Physician Referral ☐ A friend or relative referred me ☐ Internet Search ☐ Former Patient ☐ Other☐

PATIENT MEDICAL HISTORY

Name: ______________________________ **Referring Physician:** ______________________________

Family Physician: ____________________ **Have you had surgery for this injury? Yes** If so, Date: ____ No

Was this injury caused by an accident? Yes If so, Date ______ No **Is an attorney involved in this case:** Yes No

To ensure that you receive a complete and through evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you.

Leisure Activities: ______________________________

ALLERGIES: List any medication(s) you are allergic to: ______________________________

Are you latex sensitive? Yes No List any other allergies we should know about: ______________________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Which of the following OVER THE COUNTER medications have you taken in the past week?

Yes No Aspirin
Yes No Tylenol
Yes No Advil/Ibuprofen/Motrin
Yes No Aleve
Yes No Antacids
Yes No Laxatives
Yes No Decongestants
Yes No Antihistamines
Yes No Vitamins/ mineral supplements

Prescription Medications taken in the past week? (INCLUDING pills, injections, and/or skin patches)

Yes No Pain Medications
Yes No Muscle Relaxers
Yes No Anti-inflammatories

Please List or Provide a listing of medications(s):

____

____

Please describe any significant injuries, surgeries, or hospitalizations for which you have been treated (including fractures, dislocations, sprains) with approximate date of injury:

Date	Injury / Surgery / Hospitalization	Date	Injury / Surgery / Hospitalization
________	____________________	________	____________________
________	____________________	________	____________________

Please check any of the following Medical Professionals or services for this injury / episode.

_______ Chiropractor
_______ General Practitioner
_______ Neurologist
_______ Orthopedist
_______ Podiatrist
_______ Emergency Room Care
_______ CT Scan
_______ MRI
_______ X-Rays
_______ Physical Therapy
_______ Occupational Therapy

Have you EVER been diagnosed as having any of the following conditions?

_____ Asthma / Bronchitis / Episysma
_____ Heart Problems-What kind:__________
_____ High Blood Pressure
_____ Stroke / TIA
_____ Kidney Disease
_____ Anemia
_____ Blood Clot / Emboli
_____ Gout
_____ Epilepsy / Seizures
_____ Thyroid Trouble / Goiter
_____ Osteoporosis
_____ Hepatitis
_____ Tuberculosis
_____ Diabetes
_____ Multiple Sclerosis
_____ High Cholesterol
_____ Cancer/ Chemotherapy/ Radiation What kind:__________
_____ Severe/Frequent Headaches
_____ Vision / Hearing Difficulties
_____ Osteoarthritis
_____ Rheumatoid Arthritis
_____ Hernia
_____ Varicose Veins
_____ Any Pins or Metal Implants
_____ Joint Replacement
_____ Depression
_____ Chemical Dependency (Including Alcoholism)
_____ Bowel/ Bladder Problems
_____ **Pacemaker**/Other implant
_____ Neuropathy

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Do you currently smoke? Yes No **Are you aware of your Diagnosis?** Yes No

Do you currently exercise 3-5 times per week? Yes No **Do you need to speak to a social worker concerning your rehabilitation?** Yes N

Have you recently noted:

Yes No Weight loss / gain
Yes No Nausea / vomiting
Yes No Dizziness / Lightheadedness
Yes No Fatigue
Yes No Weakness
Yes No Fever / Chills / Sweats
Yes No Numbness or Tingling
Yes No Speech Difficulties
Yes No Ringing in ears
Yes No Chances in vision

Parent / Guardian Signature: ______________________________ **Date:** ______________

Therapist Signature: ______________________________ **Date:** ______________

Other Party Liability
Patient Information Form

Phone: 785-291-4013
Fax: 785-290-0771
Maildrop: 217D5
www.bcbsks.com

Section 1

Member name ______________________________
Last First MI

Member's ID No. ______________ Provider ______________
Patient Name ______________________________
Last First MI

Section 2

Annually, Blue Cross and Blue Shield of Kansas verifies whether or not your family has duplicate coverage. *If it has been a year since your last visit to this provider, please answer the following:*

1. Are you, your spouse or your dependent children enrolled in other group health insurance (**not** Medicare or SRS/Medicaid)? ☐ Yes ☐ No

   If Yes: Name of Policyholder ______________
   Name, Address and phone number of other insurance company ______________
   ID No., Group and/or Policy No. ______________
   Employer/Group ______________

We also attempt to verify if injuries, carpal tunnel, heart attacks, hernias and back problems are eligible to be covered by worker's compensation or auto insurance. If your visit is related to an injury or one of the conditions described above, please answer the following questions *unless this is a follow-up visit and you have been filled out this form previously.*

1. Date of accident or onset of symptoms ______________
2. Description of injury (body part) or condition ______________
3. How did this injury/condition occur? ______________

Section 3

1. Where did it occur? ☐ School ☐ Home ☐ Work ☐ Other (explain)
   ____
1. Was your accident/condition work related? ☐ Yes ☐ No
   If Yes, are you self-employed? ☐ Yes ☐ No
1. Was the injury the result of a motor vehicle or of physical contact with a motor vehicle? ☐ Yes ☐ No
   If yes, type of vehicle involved: ☐ Car ☐ Truck ☐ Motorcycle
   If Motorcycle: a. Are you the owner? ☐ Yes ☐ No
   b. If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ☐ Yes ☐ No
1. Was another party responsible for your injury or condition? ☐ Yes ☐ No

Coordinating benefits places responsibility with a proper carrier, which helps keep rates lower for ou

Your signature required ______________ **Date / /**

An Independent Licensee of the Blue Cross and Blue Shield Association.

CONSENT TO TREAT:

I consent to the procedures which may be performed during my treatment and care at **ADVANCED THERAPY & SPORTS MEDICINE**, including emergency treatment or services. These may include, but are not limited to, any and all testing and measurements necessary for my evaluation, and any and all therapeutic procedures (exercise, joint metabolism, manual stretching, etc.) necessary for my treatment and under the direction and supervision of my therapist. I understand that is my right and responsibility to question freely any treatment, and in no way am I being guaranteed a certain result from the procedures rendered. That being noted, it is the responsibility of your therapist to practice current and reasonable experiential and evidence based methods.

Initials:________

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT):

I hereby acknowledge that I have received a copy of the *Notice of Privacy Practices* for **ADVANCED THERAPY & SPORTS MEDICINE.** In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initials:________

NOTICE OF FINANCIAL POLICY RECEIPT:

I hereby acknowledge that I have received a copy of the *Financial Policy* for **ADVANCED THERAPY & SPORTS MEDICINE** and agree to the terms and conditions of its contents

Initials:________

NOTICE OF NO SHOW/CANCELLATION POLICY:

I hereby acknowledge that I have received a copy of the *No Show/Cancellation Policy* for **ADVANCED THERAPY & SPORTS MEDICINE** and agree to the terms and conditions of its contents

Initials:________

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care. As a patient, you may want our facility to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE. * Include your family physician if you are a self-referred patient. **

Name: ________________________________ Relation to patient ____________________

Name: ________________________________ Relation to patient ____________________

Name: ________________________________ Relation to patient ____________________

I understand and have fully received & reviewed the contents of the Consent to Treatment, Notice of Privacy (HIPAA Acknowledgment/Consent), Financial Policy, and No Show/Cancellation Policies

__________________________ __________________

Patient/Legal Guardian Signature Date

____

Witness