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	Aleve	Yes No	Decongestants
Yes No	Tylenol	Yes No	Antacids	Yes No	Antihistamines
Yes No	Advil/Ibuprofen/Motrin	Yes No	Laxatives	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	_____ Orthopedist	_____ CT Scan	_____ Physical Therapy
_____ General Practitioner	_____ Podiatrist	_____ MRI	_____ Occupational Therapy
_____ Neurologist	_____ Emergency Room Care	_____ X-Rays	

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

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

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

Parent / Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

MANDATORY MEDICARE AS SECONDARY PAYER QUESTIONNAIRE

Patient Name _____
Acct # _____
Medicare # (exactly on Red-White-Blue Government Medicare Card) _____

Please read and respond to each of the following:

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name an phone number of the Home Health Agency:

Not Applicable:_____
Home Health Agency Name: _____
Home Health Phone Number: _____

2. If you are entitled to benefits under the Black Lung Program, Department of Veteran Affairs or othe government program, please provide the name, address and phone number of the program.

Not applicable _____
Program Name: _____
City, State & Zip: _____

Note: This government program you've listed in question #2 will be primary to Medicare.

3. Was your illness/injury due to any of the following:

_____ Not Applicable Accident Date:_____
_____ Work-Related Accident Date:_____
_____ Automobile Accident Date:_____
_____Accident on Property (other than your own)
(Example: Store, restaurant, etc.)
Please give details of the accident:_____

Please provide the name, address and contact information of the **liability insurance:**

Insurance Name: _____
Address: _____
City, State & Zip _____
Phone:_____
Contact: _____

4. Do you feel you have a right to be compensated by a party who may have caused the injury or illness?

_____ **Yes** _____ **No**

Note: Medicare regulation requires us to file with the above liability insurance first, even if they will not pay directly or immediately.

Patient Name _____ **Patient Account Number** _____

5. If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness?

_____ **Yes** _____ **No**

If yes, Please provide the attorney information below:

Attorney Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

6. If you have received a kidney transplant or are currently receiving dialysis for end Stage Renal Disease, Please give the date of the transplant or start of dialysis Date: _____

Note: if the date is less than 30 months ago, are you currently covered under group insurance provided by you or a family member employer?

_____ Yes- the group insurance will be primary

_____ No-Medicare will be primary

7. If none of the above applies to you and your Medicare coverage is due to age or disability, do you have group insurance coverage through you or a family member's current employer?

_____ Yes- the group insurance will be primary

_____ No-Medicare will be primary

8. Do you have any benefits through TRICARE (Formerly Champus)? _____ Yes

_____ No

If you answered yes to questions 6, 7, or 8 please provide the group insurance information:

Insurance Name: _____

Address: _____

City, State & Zip _____

Phone:_____

Employer: _____

Insured's Name: _____

Patient's Signature _____ **Date**_____

Thank you for your Cooperation!

MEDICARE FINANCIAL POLICY STATEMENT

Advanced Therapy & Sports Med, LLC-Great Bend

Progressive Therapy & Sports Medicine-Larned

Progressive Physical Therapy Center-Hays

Advanced Therapy and Sports Med LLC will bill your insurance as a courtesy to you. You are ultimately responsible for the entire bill. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference that remains.

You are responsible for the deduction and your percentage of services not paid by your insurance. If your deductible has not been met at the time you receive services, you may need to pay a portion of the services at that time. If you do not have supplemental insurance. We require that you pay 10% at the time of services to reduce the total amount that will be billed or refunded once Medicare payment is complete.

If any payment is made directly to you for the services billed by us, you recognize an obligation to promptly submit the same payment to Advanced Therapy & Sports Med LLC.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collecting agency fees, and attorney fees.

Medicare patients: Physical therapy services provided must be medically necessary. Medicare payments amounts are combined with speech therapy services provided in 2022. Total services over $2150.00 will continue to require additional verification by the provider that **ARE** medically necessary.

Have you received any physical or speech therapy as an outpatient, in skilled nursing or home health in 2022?

Yes____ No ____

If so, what facility or agency provided the services? _____

Approximate dates of services?_____

X_____ Date_____

Patient/Guardian/ Responsible Party

A copy of this signed policy has been given to the patient/ responsible party._____

Initial and date of facility representative

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