



The One on One Approach!

DATE _____ REFERRING DOCTOR: _____ Dr. Phone #: _____
PRIMARY CARE PHYSICIAN: _____ Dr. Phone #: _____

Patient Information

Last Name _____ First _____ M.I. _____
Address _____ Apt# _____
City _____ State _____ Zip Code _____
Phone # _____ Cell # _____ SS# _____
Date of Birth _____ Age _____ Sex M _____ F _____ Drivers License # _____
Marital Status: M _____ S _____ D _____ Spouse's Name _____
Emergency Contact: _____ Relationship: _____ Phone #: _____
Date of Injury _____ Injury Type: Work _____ Auto _____ Home _____ Surgery _____ Other: _____
Is there an attorney involved Yes ___ No ___ Who may we thank for your referral other than your Doctor? _____

PATIENT WORK INFORMATION

Employer: _____ Full _____ Pt-time _____ Not working _____ Retired _____ Disability _____
Employer's Address: _____ Suite # _____
City: _____ State: _____ Zip Code: _____
Work Phone #: _____ Supervisor: _____
Employee Id Number: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance: _____ Phone #: _____ Fax #: _____
Address _____ Suite # _____
City _____ State _____ Zip Code _____ Subscriber Name: _____
Subscriber SS #: _____ Subscribers Date of Birth: _____ Relationship to Subscriber: _____
Policy #: _____ Group # _____ Certificate # _____

SECONDARY INSURANCE INFORMATION

Insurance: _____ Phone #: _____ Fax #: _____
Address _____ Suite # _____
City _____ State _____ Zip Code _____ Subscriber Name: _____
Subscriber SS #: _____ Subscribers Date of Birth: _____ Relationship to Subscriber: _____
Policy #: _____ Group # _____ Certificate # _____

AUTO INSURANCE INFORMATION

Insurance: _____ Phone #: _____ Fax #: _____
Address _____ Suite # _____
City _____ State _____ Zip Code _____
Subscriber Name: _____ Policy #: _____ Claim #: _____
Adjuster's Name: _____ Phone #: _____ Fax #: _____

WORKERS' COMPENSATION INFORMATION

Employers' Name (at time of injury) _____ Supervisor: _____
W/C Insurance Name _____ Phone # _____ Fax #: _____
Address _____ Suite # _____
City _____ State _____ Zip Code _____
Claim #: _____ Adjuster Name _____ Phone # _____ Fax #: _____

ATTORNEY INFORMATION

Attorneys Name: _____ Phone #: _____ Fax #: _____
Address _____ Suite # _____
City _____ State _____ Zip Code _____ Subscriber Name: _____

AUTHORIZATION TO PAY BioSport Physical Therapy

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to BioSport Physical Therapy and I am financially responsible for non-covered services. I also authorize BioSport Physical Therapy to release any information to process this claim.

Patient Signature: _____ DATE _____



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Patient Name: _____ Injury Date: _____

Describe how injury occurred? _____

Type Of Surgery: _____ Surgery Date: _____

Describe previous treatment for this condition: _____

Have you recently noted?

- Weight loss / gain
- Weakness
- Nausea / Vomiting
- Fever / Chills / Sweats
- Fatigue
- Numbness / Tingling

Have you ever been diagnosed as having any of the following?

- Cancer
- Kidney Problems
- Heart Disease
- Heart Attack
- Heart Murmur
- High Blood Pressure
- Pacemaker
- Pregnant
- Depressions
- Nervous Disorder
- Chemical dependency
- Multiple sclerosis
- Ulcer
- Stroke
- Rheumatoid arthritis
- Surgeries
- Circulation problems
- Asthma
- Breathing Problems
- Thyroid Problems
- Lung disease
- Diabetes
- Other arthritic conditions
- Other
- Hernia
- Asthma
- Epilepsy, seizures
- Metal Implant
- Allergies
- Allergies to cold
- Allergies to hot

Do you have now (in the past week) any of the following?

- Headaches
- Abdominal Pain
- Change in Vision / Hearing
- Urinary Problems / Infections
- Unusual Shortness of Breath
- Any previous injury that may affect current care
- Repetitive Nausea / Vomiting
- Indigestion / Heartburn
- Long Standing Constipation
- Cramps in legs when walking
- Neck Swelling / Lumps
- Recurrent Diarrhea
- Trouble Swallowing
- Hurried need to urinate
- Leg / ankle swelling
- Allergies / Skin sensitivity
- Insomnia
- Fainting
- Epilepsy, seizures
- Pain at night
- Dizziness

Explain & give approximate dates for any items indicated above: _____

Are you currently taking Medications? Yes / No

Medication	Reason	Dosage	Frequency	How Long

Your Injury

Please mark on the body where your pain is located.⇒

Does pain radiate (travel) into arms or legs? Yes / No

Type of pain:

Sharp / Burning / Aching / tingling / numbness

Other: _____

Rate your (average) pain on a 0-10 scale.

(0=no pain 10= severe) _____

Is there anything else you would like to include?

Patient Signature: _____ Date: _____

Therapist Signature: _____ 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.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or service. **For Payment:** We may use and disclose medical information about you so that treatment and service received 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 healthcare 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 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 Security 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 the law. **For Protective Services for the President and others:** We may disclose medical information to authorized federal officials 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 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 Rights 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. 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 reason 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 Practice.

Patient or Personal Representative Signature

Date