DPT Notes:

Diagnostic Code #_____

OFF-SEASON
SPORTS & PHYSICAL THERAPY

Patient Information

Confidential Patient Information

Date: _____ How did you hear about us?_____

Patients Full Legal Name* :_____ **For insurance billing purposes*

What do you prefer to be called: _____ pronouns:_____

Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ E-Mail Address:_____

Date of Birth: _____ Current Age: _____

Sex assigned at birth (circle one) Male /Female Gender Identity: _____

Do you want appointment reminders sent your email or text? (circle one)

Emergency Contact Information

Name:_____ Relationship:_____

Phone Number: _____

Address:_____

Medical History

Please list any surgeries you have had. **If none please indicate N/A**:

Surgical procedure: _____ Date/Year: _____

Surgical procedure: _____ Date/Year: _____

Surgical procedure: _____ Date/Year: _____

Have you had any complications due to your past surgeries? If none please indicate N/A:

_____

_____

Primary Care Physician: _____Phone: _____

Referring Physician: _____Phone: _____

Other Specialist (please specify): _____

Please list any medications you currently take**. If none please indicate N/A:**

Medication	Dose	Duration	Adverse side effects
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies that you may have:

_____

_____

Do you have, or have ever had, any of the following diseases or conditions? **(Circle at least one)**

No past medical history	Emphysema/Glaucoma	Multiple Sclerosis
Fainting/Seizures	Muscular Dystrophy	Anemia
Osteoporosis	Arthritis	Heart Surgery/Pacemaker
Blood Disorder	Hepatitis	Shingles
High/Low Blood pressure	Sinus Problems	Chemotherapy
Tuberculosis	Circulation Problems	Kidney Problems
Currently Pregnant	Liver Disease	Diabetes
Difficulty Breathing	Mitral Valve Prolapse	Alcohol/Drug Abuse
Frequent Neck Pain	Frequent Headaches	Cancer
HIV and /or AIDS	Ulcers/Colitis	Lower Back Pain

Other: _____

Injury Information

The reason for this visit is a result of: Sport / Chronic / Trauma / Other

Please explain what happened: _____

_____

_____

When did you first notice this condition?: _____

What is the **exact** location of your symptoms?:_____

Do your symptoms spread? Yes / No Where?:_____

Is your condition progressively: Worsening Improving Unchanged

What makes your condition worse?: _____

What makes your condition better?: _____

Hand dominance: Right or Left Leg dominance: Right or Left

Have you ever had this condition in the past? Yes / No

Have you ever had physical therapy before? Yes / No

Were you treated for this condition? Yes / No

If so was the treatment helpful? Yes / No

Where were you treated for this condition?:_____

Diagnostic tests for this condition: None X-Ray MRI CT Scan Bone Scan

If applicable, please write the name of the physician who ordered the tests: _____

Athlete / Activities Section

Primary Sport/Activity: _____ Secondary Sport/Activity: _____

Coaches/ Teachers Name:_____ Coaches / Teachers Name:_____

Phone #: _____ _____ Phone #: _____

Primary Position:_____ Primary Position:_____

Years Played/ In Activity:_____ Years Played/ In Activity:_____

# of different sports/activities participated in throughout the year: _____

Where do you participate in you sport / activity? *School / Program / Team / Facility*: The Name:_____

Athletic Trainer / Personal Trainer: Yes / No

Name:_____ Phone #_____

E-mail Address: _____

Any other coaches or player personal you work with (ex: strength coach, performance coach)?

_____

Patient Signature

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided. If you are unable to keep your scheduled appointment, please contact us with 24 hour notice. If you are more than 15 minutes late you may be asked to reschedule. **There is a $65 fee for no-show or cancellation with less than 24 hour notice.**

Signature:_____ Date:_____

(Patient over the age of 18 or Legal Guardian)

OFF-SEASON
SPORTS & PHYSICAL THERAPY

Consent of Treatment

I,_____, hereby understand the terms and conditions of this
(Please print your / patients name)
document. I am authorizing all certified/insured staff of OFF-SEASON Sports and Physical Therapy to administer necessary treatment protocol(s). I understand that health and/or accident insurance policies are an arrangement between the insurance carrier(s) and myself. I also am aware that there is no guarantee to the results that may be obtained.

Print your name:_____ Your Signature: _____

Date:_____

We offer the additional services of dry needling and personal training. Are you interested in hearing more about these services from your treating PT? Yes_____No_____

Consent of Treatment of a Minor

I hereby authorize the staff of OFF-SEASON Sports & Physical Therapy to administer physical therapy as deemed necessary to my son/daughter; their full

name:_____

_____ _____

Signature: Patient **or** Legal Guardian Date

OFF-SEASON
SPORTS & PHYSICAL THERAPY

Receipt of Privacy Practices (HIPAA)

I acknowledge that I received a copy of The Off-Season Sports and Physical Therapy document of privacy practices (HIPAA).

_____

Patient Name (Print)

_____

Signature: Patient or Legal Guardian

_____

Date

OFF-SEASON
SPORTS & PHYSICAL THERAPY

Financial Agreement

Attendance:

- Offseason Sports and Physical Therapy reserves the right to **charge a sum of $65** in result of a "no show" or a "cancelation without notice": within 24 hours. Charges will be forwarded to client or guardian in charge of client. We will collect a credit card on file and assess this charge automatically. Insurance companies are not responsible to cover such fees.
- Offseason Sports and Physical Therapy also reserves the right to refuse treatment to any client for persistent lack of punctuality "tardiness" or consistent failure to attend allotted appointment time slot.

Lien on Settlement:

- We require a lien on settlements, which is a promise of payment that is the patient's responsibility to obtain from his/her attorney and to be returned within one week from start date of therapy. Client(s) may also sign consent for Offseason Sports and Physical Therapy to contact his/her attorney in order to obtain proper documents. Failure to comply with proper procedures may result in termination of treatment.
- For client charts in litigation, we will bill auto/WC/health insurance directly. Please be aware that you are responsible for the balance, not the individual(s) being sued. Liability action against someone else, does not clear you for refusal of payment to us.

Insurance Responsibility and Co-payment:

- Patients with a co-pay are required to make payment(s) at time of treatment, unless other arrangements have been made beforehand. Deductible/Percentage payments will be billed once difference is collected from the client's insurance company. Payment will be due within 30 days of invoice date.
- In case of insurance change during timeline of therapy, client must notify Offseason Sports and Physical Therapy so proper billing adjustments can be made.
- Payments for therapy services must be paid in a timely fashion. If we have not received payment from your insurance company within contracted timeline, we have the right to defer reimbursement to the client. Your insurance contract is between you and your insurance carrier. If the client is unsure of treatments or procedures covered, it is the client's responsibility to perform their due diligence. The client is ultimately responsible for payment of therapy services. Off-Season Sports and Physical Therapy submits claims as a courtesy to our clients.
- **Bills will be sent by email , please make sure your email address on file is correct.**

I _____, hereby agree to the terms and conditions above.
(Please print your / patients name)

_____ ___ _____
Signature: Patient or Legal Guardian Date

HIPAA

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.

Examples of how we (Doctor and staff) might have to use or disclose your health care information.

- To another healthcare provider if it is necessary to refer you to them.
- Examination, treatment, and billing records to another party, such as an insurance carrier, or your employer if they are potentially responsible for payment of your services.
- For other administrative purposes, or to contact you to provide appointment reminders, information about treatment alternatives, or other health related information via your answering machine/service/voice mail, wireless phone, or e-mail. You have the right to refuse to give us authorization to contact you.

We will not sell or provide any of your health information to any outside marketing organization. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in circumstances such as providing health care services to you in an emergency. You may revoke your authorization to us at any time, in writing. We will not be able to honor your revocation request: 1.) If we have already released your health information before we received your request to revoke your authorization, or 2.) if you were required to give your authorization as a condition of obtaining insurance and the insurance company must contest any of your claims.

If there are health care providers, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not us to disclose your healthcare information. You have the right to receive confidential communication regarding your health information and to inspect and copy your health information for (7) years from the date that the record was created or as long as the information remains in our files.

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. You have the right to request an accounting of the disclosures we have made of your health information for the last six years before the date of your request, except in certain circumstances. We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail, and changes will apply for all of your health information in our files.

Information we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules (ex: other who see your mail or hear your phone messages).

You may complain to us (receptionist) or the Secretary for health and human services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint.

Additional Information:
HIPAA is the Health Insurance Portability and Accountability Act of 1996. The revised and updated privacy rule portion of HIPAA went into effect in Sept. 15, 2003. You may further research the polices and guidelines of HIPAA via the internet.
Contact:

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