



314 East First Street
6700 Kirkville Road

Date ___/___/___

Account Number _____

Patient Name:

(Last) _____ (First) _____ (MI) _____
Email address _____ Do you want to be included in electronic newsletter Y N
Address _____ City _____
State _____ Zip _____ Home Phone (____) _____ - _____
Cell Phone (____) _____ - _____
Employer _____ Work Phone (____) _____ - _____
Employer Address _____
Social Security # _____ Sex M F Birthdate ___/___/___
Marital Status M S D W

Insurance Policy Holder

Name (Last) _____ (First) _____ (MI) _____
Birthdate ___/___/___ Policy Holder SS# _____
Address _____
City/State/Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____
Policy Holder Employer _____
Relationship to Patient _____
Emergency Contact _____ Phone (____) _____ - _____
Referring Physician _____
Address of Referring Physician _____
Phone (____) _____

Accident Information: Work Auto Other _____ Date of Accident ___/___/___

Details of accident _____

Body Part being treated: _____ **Date of Rx** ___/___/___

INSURANCE INFORMATION:

Primary Insurance _____ Phone (____) _____ - _____ Fax
(____) _____ - _____ Ins. Address _____
City _____ State _____ Zip _____
ID/Policy/Claim# _____ Group # _____
Effective Date ___/___/___

Secondary Insurance _____
Phone (____) _____ - _____ Fax (____) _____ - _____
Ins. Address _____
City _____ State _____ Zip _____
ID/Policy/Claim# _____ Group # _____
Effective Date ___/___/___



Authorization and Assignment of Benefits

I hereby authorize Championship Physical Therapy, PC to apply for benefits from my insurance carrier(s) listed above and further authorize payment directly to Championship Physical Therapy, PC of the medical benefits, if any, otherwise payable to me for services rendered by Championship Physical Therapy, PC.

Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Championship Physical Therapy, PC for my services furnished to me by Championship Physical Therapy, PC. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Championship Physical Therapy, PC to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of _____ (patient). Further, I authorize Championship Physical Therapy, PC to disclose complete information concerning records regarding the illness or accident of _____ (patient) to any collateral source in the case of Medicare, the Social Security Administration and the Health Care Financing Administration that will pay part or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information. I understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Championship Physical Therapy, PC reserves the right to pursue delinquent accounts via third party collection agencies or attorneys. In the event my bill is referred to collection, I agree to pay the prejudgment interest, reasonable attorney fees, court costs and service of process costs to said physical therapist in addition to the amount owed for the services rendered.

Estimated Portion Due from Patient:

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical or therapists and/or physical therapist assistants associated with Championship Physical Therapy, PC .

X _____

Signature of Patient or Guarantor, if Minor Date Witness



Notice of Privacy Practices

In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed. Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claim or for health care operations, which may include but are not limited to: 1) Receive Payment, 2) Verify Insurance, 3) Conduct Quality Assessment, 4) Care Coordination/Management, 5) Manage Our Business, 6) Assist Other Covered Entities With Their Health or Business Operations, 7) Accreditation, Certification, Licensing, or Credentialing, 8) Disclosure to the Secretary of the United States Department of Health & Social Services, 9) Health Oversight Agencies, 10) To prevent a serious threat to Health or Safety, 11) Research, 12) Workman's Compensation, 13) Public Health & Safety, 14) Legal, National Security or Law Enforcement, 15) Personal Physician, Team Physician, Athletic Director or Coach, 16) To you or your Designee upon written request, 17) Other uses and disclosures of PHI only after your written authorization.

All Evaluations, Progress Notes as well as significant changes in Medical Conditions will be reported via Fax, Phone, and or Mail to your Referring Physician and possibly Primary Care Physician. All insurances will be verified with pertinent PHI being released to the Insurance Company(s) necessary to process claims. All patients will be asked to sign in at the Front Desk upon arrival and names will be announced. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign on the sheet, not to have your name announced, not to bill claims electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to accommodate your needs. If you have any questions, please ask to speak to the Physical Therapist.

Thank You,

Patient Signature

Date



PATIENT MEDICAL HISTORY

Date: _____

Patient's Name: _____
Age: _____ Occupation: _____ Left or Right handed (circle) _____
Family Physician: _____
Referring Physician: _____
How did you hear about us? M.D. _____ Friend/Name _____ Other _____

When did this problem begin? _____

If accident, place where occurred: Home Work Auto Other _____

Briefly describe what happened and/or what is bothering you: _____



On a scale from 0 (no pain) to 10 (severe pain) please rate your pain level: _____

What makes you symptoms worse? _____

What makes your symptoms better? _____

Have you been treated previously for this condition? Yes No

Where? _____ When? _____

Are you currently taking any medications? Please circle: YES NO

Please list: _____

Do you have any allergies to any medications? Please circle: YES NO

Please list: _____

Please list all past surgeries: _____

What type of testing have you had for this condition? Please Circle: X-Ray MRI CTScan Bone Scan Other If yes explain results:

Do you exercise regularly? Please circle: Yes No

If yes, what is your primary activity? _____

Person to contact in case of an emergency if no one is at your home phone number:

Name: _____ Phone #: _____ Relationship: _____



Check appropriate history of past/present conditions:

Heart Condition	YES__	NO__	Tuberculosis	YES__	NO__
High Blood Pressure	YES__	NO__	Hepatitis/Liver	YES__	NO__
Circulation	YES__	NO__	Kidney or Bladder	YES__	NO__
Phlebitis/Blood Clots	YES__	NO__	Mental or Emotional	YES__	NO__
Asthma or Emphysema	YES__	NO__	Lyme disease	YES__	NO__
Diabetes	YES__	NO__	Cancer	YES__	NO__
Thyroid	YES__	NO__	Arthritis	YES__	NO__
Epilepsy/Seizure/ Convulsions	YES__	NO__	Ulcer or Gastrointestinal	YES__	NO__
Stroke	YES__	NO__	Drug/alcohol addiction	YES__	NO__
Pacemaker	YES__	NO__	Nicotine/caffeine addiction	YES__	NO__
Broken/fractured bones	YES__	NO__	Hypoglycemia	YES__	NO__
Low back, hip, leg pain	YES__	NO__	Pregnancy (current)	YES__	NO__
Neck, shoulder, arm pain	YES__	NO__	Allergies/skin allergies	YES__	NO__
Jaw pain/TMJ	YES__	NO__	Herpes/shingles	YES__	NO__
Headaches/head injuries	YES__	NO__	Tendonitis/bursitis	YES__	NO__
Sinus problems	YES__	NO__	Hypoglycemia	YES__	NO__
Sprains/strains	YES__	NO__	Aids/HIV	YES__	NO__
Fatigue	YES__	NO__	Thyroid problems	YES__	NO__

What are your goals for physical therapy?

Signature: _____ **Date:** _____

Parent or Guardian signature if minor: _____ **Date:** _____