SPARGO PHYSICAL THERAPY

Patient Information

First Name: _____ Last Name: _____ MI: _____

M/F_____ Date of Birth: _____ Phone Number: _____

Email Address: _____

Address: _____

City/State/Zip_____

Referring MD_____

Primary MD _____

Billing Information

Primary Insurance: _____ ID#_____

Policy Holder Name_____ Relationship to insured: _____

Insured DOB: _____ Insured's Employer: _____

Secondary Insurance: _____ ID#: _____

Policy Holder Name: _____ Relationship to Insured: _____

Insured DOB: _____ Insured's Employer_____

Are you presently receiving Home Health Services (ie. Visiting Nurse, Physical Therapy, Home Companion): YES/NO

If yes, Name of Home Health Agency: _____

Is this work related or automobile injury? YES/NO (If yes, fill in the following information)

Date of Injury: _____ Claim #_____

Contact Person_____

Auto claims: Do you have Medical Benefits (MedPay) on auto policy? YES/NO

SPARGO PHYSICAL THERAPY

Medical History

List your **current** prescription and/or non-prescription medications: _____

_____

Allergies: _____ Are you latex sensitive? YES/NO

Any surgeries or other conditions in which you were hospitalized, including dates: _____

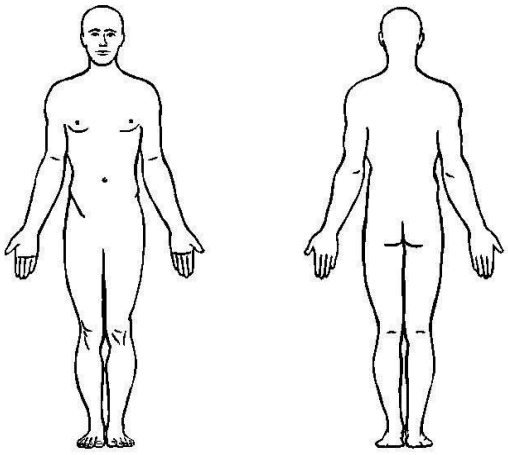
_____

Do you **currently** have any of the following? (check all that apply)

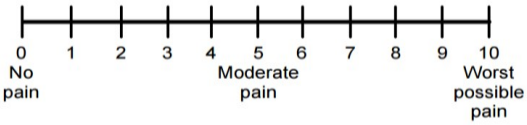
- ☐ Change in appetite
- ☐ Change in bowel/bladder
- ☐ Visual changes
- ☐ Dizziness
- ☐ Fever/chills/sweat
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ History of falls
- ☐ Weakness/Fatigue
- ☐ Weight loss/gain

Have you **ever** had any of the following? (Check all that apply)

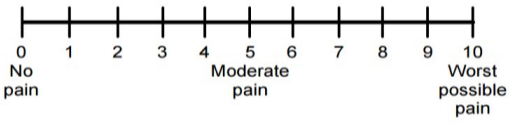
- ☐ Asthma/Lung Disease
- ☐ Heart Disease
- ☐ Cancer/ Type:
- ☐ Pacemaker
- ☐ Stroke/TIA
- ☐ High Blood Pressure
- ☐ Blood Clot/Emboli
- ☐ Infectious Disease
- ☐ Thyroid Disease
- ☐ Kidney Problems
- ☐ Epilepsy/Seizures
- ☐ Thyroid Disease
- ☐ Kidney/Liver Problems
- ☐ Epilepsy/Seizures
- ☐ Diabetes/ Type: _____
- ☐ Depression/Anxiety
- ☐ Osteoporosis
- ☐ Rheumatic Arthritis
- ☐ Other:_____



Circle your pain level **RIGHT NOW**



Circle your pain level **AT WORST**



Signature: _____ Date: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION OUR PRIVACY PLEDGE

Protecting your privacy is of upmost importance to us. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (HIPPA). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name: _____

Signature: _____ Date: _____

Payment Policy:

I, the undersigned, have insurance coverage with _____with a _____ COPAY and assign directly to SparGO Physical Therapy LLC all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. SparGO Physical Therapy LLC is not responsible for your insurance misquoting medical benefits. I hereby authorize SparGO Physical Therapy LLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. I agree to pay my deductible and/or copayment upon each visit. I understand I am responsible for obtaining any necessary referrals from my physician, if required.

Signature:_____Date:_____

Credit Card Authorization Form

Signature of cardholder authorizes SparGO Physical Therapy LLC to charge appropriate **deductible/copay/co-insurance** amounts on my credit card.

Please contact us immediately if you have any questions concerning your invoice or statement.

Card Holder Name: _____

Expiration Date: _____

Verification Code: _____

(three digit code on back of card)

Billing Address: _____

Phone Number: _____

Date: _____ Signature: _____

Card Type:

Card Number: