ENDURANCE SPORTS PERFORMANCE & REHABILITATION

Name:_____ D.O.B:_____ Age: _____

Address:_____ City:_____ Zip Code_____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ Email:_____

Appointment reminders : ❑ Text ❑ Email ❑None ***Cell Carrier for text reminders***: _____

Emergency Contact Name: _____ Number: _____

If Referred by a Physician please provide name or office: _____

How did you hear about Endurance Sports? _____

Financial and Information Release

Payment is expected at the time of service and I understand that I must pay any copay, coinsurance, or deductible due at the time of service unless other arrangements have been made with Endurance Sports Performance and Rehabilitation. I understand payment is expected at each treatment session for certain procedures or supplies not covered by my insurance company. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount of services provided. I understand that the definition of "non-covered" is made by my insurance company. I further agree to pay, upon receipt, any bill from Endurance Sports Performance and Rehabilitation for services or products not covered by my insurance company. **I agree to Endurance Sports Performance and Rehabilitation cancellation policy and agree to give 24 hours notice of cancellation or I will be charged a $25 late cancellation fee. If I fail to give any notice, resulting in a no show I will be charged a $50 fee.**

I consent to the treatment, which my therapist deems necessary. I authorize the release/transfer of all records regarding treatment to all agencies concerned in this case. If it is requested by my physician, I authorize Endurance Sports Performance and Rehabilitation to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

Printed Name of Patient: _____

Signature of Patient or Guardian: _____ Date: _____

600 S Airport Rd, Bld B, Suite C, Longmont, CO 80503 •(720) 491-3402 • Fax (720) 491-3468
info@endurancesportsandrehab.com • www.endurancesportsandrehab.com

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Patient Health Questionnaire

Date of Injury/Accident:_____ Date of Surgery:_____

Main complaints/symptoms_____

_____

Pain Level: At best: ____/10; At worst:____/10 Current:____/10 (0=no pain, 10=worst)

What intensifies your pain?_____

What alleviates your pain? _____

List functional limitations/difficulties (tasks during the day at home, work, or recreationally):

1._____ 2. _____ 3. _____

Allergies: (Please list medication allergies) _____

_____

Medications: (Currently taking)_____

_____

Please list past surgeries, including minor:

Surgery: Date:

_____

_____

Medical History: Please check all that apply

	High Blood Pressure		Seizures		Pregnant
	Heart Condition		Diabetes		Stroke
	Cancer		Dizziness		Rheumatoid Arthritis
	Pacemaker		Osteoporosis		Other:

Print name of patient_____

Signature of patient or guardian_____ Date_____

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Notice of Privacy Practices
Effective 12/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU DURING THE COURSE OF TREATMENT MAY BE USED AND DISCLOSED. IT ALSO INFORMS YOU OF HOW TO OBTAIN THE INFORMATION FOR YOURSELF.

Our Responsibilities

- We are required by law to maintain the privacy of your health information and to make available to you this notice of our legal duties and privacy practices regarding health information about you. We will abide by the terms of this notice and will notify you if we cannot agree to a specific restriction that you may have requested.

How we may use and disclose Medical Information about you

- The following are reasons for use to utilize and disclose your Medical Information: for treatment, payment, health care operations, business associates, individuals involved in your care or payment for your care, research, future communications, as required by law, law enforcement/legal proceedings, and state specific requirements. We will utilize this information only with your written permission and you may revoke this agreement at any time by writing to our office manager.

Your Health Information Rights

- You have the following rights: to inspect and copy, amend, accounting disclosures, request restrictions, request confidential communication, and a paper copy of this notice.

Changes To This Notice

- We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future.

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. To file a complaint with the practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses for 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, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons 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 provide you.

By Signing below, you understand and are in agreement with this Privacy Policy.

_____ _____

Patient/Guardian Signature Date

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