PROSPORTS / ELITE REHAB

Please Fill This Form Out Completely

Name:_____DOB:_____Age:_____Date:_____

Occupation:_____ Height: _____ Weight:_____

Pharmacy Name:_____ Location or phone #:_____

Referring Physician:_____Family Physician:_____

Do you have an advance directive or living will? ( ) No ( ) Yes If yes, who_____

History of Present Illness/Condition

Reason you are seeing the doctor today?:_____

Have you been treated previously or had an X-Ray/MRI for this problem? No ( ) Yes ( ) Where?:_____

Past Medical History

Are you **right** ( ) or **left** handed ( ) **Allergies to medications** No ( ) Yes ( ) please list_____
Can you possibly be pregnant? No ( ) Yes ( )

Anemia	**No ( ) Yes ( )**	**Lung or Breathing Problems**	**No ( ) Yes ( )**
Arthritis	**No ( ) Yes ( )**	**Mental Illness**	**No ( ) Yes ( )**
Rheumatoid Arthritis	**No ( ) Yes ( )**	**Peptic Ulcer**	**No ( ) Yes ( )**
Asthma/Emphysema	**No ( ) Yes ( )**	**Psoriasis**	**No ( ) Yes ( )**
Bleeding Disorders	**No ( ) Yes ( )**	**Pulmonary Embolus**	**No ( ) Yes ( )**
Cancer	**No ( ) Yes ( )**	**Seizures**	**No ( ) Yes ( )**
Where?_____		**Stroke**	**No ( ) Yes ( )**
Diabetes	**No ( ) Yes ( )**	**Venous Thrombosis**	**No ( ) Yes ( )**
Gout	**No ( ) Yes ( )**	**Pacemaker**	**No( ) Yes ( )**
Heart Disease	**No ( ) Yes ( )**	**Osteoporosis**	**No ( ) Yes ( )**
High Blood Pressure	**No ( ) Yes ( )**	**Other**_____	
High Cholesterol	**No ( ) Yes ( )**		
HIV AIDS	**No ( ) Yes ( )**		

Family History for any of the above conditions? _____ Yes _____ No relevant family history. If yes, please explain
_____

Have you had any surgeries in the past? If yes, please list type and date of surgery:_____
_____

Social History

Marital Status: S M W D Ethnicity:_____Race:_____Preferred Language:_____
Tobacco User Any Kind? No ( ) Yes ( ) If no, when did you quit?:_____
Drink Alcohol? _____never _____occasional _____ moderate to heavy _____family history
Drug Overuse? _____never _____present _____past problem

Reviewed with patient: _____MD

PROSPORTS/ELITE REHAB

DEMOGRAPHIC SHEET

Patient Name: _____ Social Security # _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Mailing Address: _____City_____State_____ Zip: _____

Seasonal Address: _____City_____State_____ Zip: _____

Home Telephone #: _____ Cellular #:_____

Email Address: _____

Employer: _____ Employer Telephone #: _____

Emergency Contact: _____ Contact #:_____

If Not Referred By a Physician, Who Referred You: _____

Insurance Information

We will need a copy of all insurance cards and a photo ID for our records.

Primary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Secondary Insurance Carrier: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ S.S. #: _____ DOB: _____

Financially Responsible Person (If different from above)

Name: _____ Social Security No: _____

Date of Birth: _____Relationship to patient: _____

Mailing address if different from above: _____

City: _____ State: _____ Zip code: _____

Contact#: _____Employer:_____

Are your injuries related to:

_____Worker's Compensation _____Auto accident _____School athletic accident _____Other accident _____none

Date of Injury: _____/_____/_____ Chief Complaint: _____

Attorney for injury? If yes name and phone number:_____

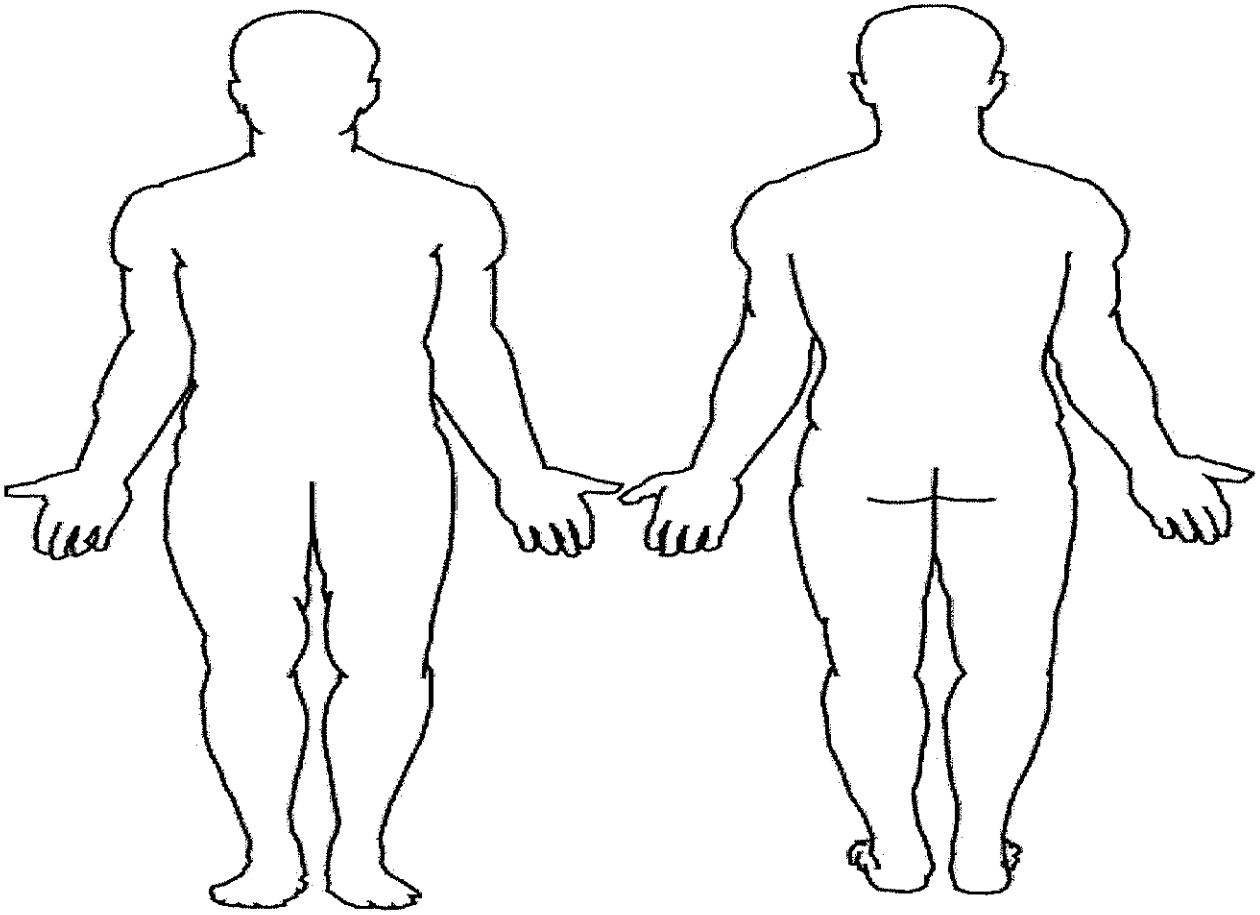
If no injury please describe your problem and date of onset:_____/_____/_____/ _____

PATIENT NAME:_____

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOU SYMPTOMS ON THE DIAGRAMS

XXXX = PAIN
0000 = NUMBNESS
//// = ACHING
**** = PINS AND NEEDLES

FRONT BACK



IF YOU HAVE NECK PAIN, WHAT PERCENTAGE OF YOUR PAIN IN NECK_____%
WHAT PERCENTAGE IS THE PAIN IN YOUR ARM_____%

IF YOU HAVE BACK PAIN, WHAT PERCENTAGE OF YOUR PAIN IS IN YOUR BACK? _____%
WHAT PERCENTAGE IS LEG?_____%

TOTAL 100%

PATIENT NAME:_____

PLEASE LIST BELOW THE PREVIOUS DOCTORS (MD, DO, CHIROPTACTOR, PAIN MANAGEMENT) YOU HAVE SEEN FOR YOUR MAIN PROBLEM:

PHYSICIAN	SPECIALTY	DATES	TREATMENT

PLEASE INDICATE WHICH DIAGNOSTICS TESTS YOU HAVE HAD IN EVALUATION FOR YOUR MAIN PROBLEM/COMPLAINT:

TEST	DATE	TEST	DATE
PLAIN X-RAY		MRI	
BONE SCAN		EMG/NCV	
MYELOGRAM		DEXA SCAN	
CT SCAN		ARTHROGRAM	
DISKOGRAM		OTHER	

PLEASE CHECK WHICH TREATMENTS YOU HAVE HAD FOR YOUR MAIN PROBLEM/COMPLAINT AND INDICATE WHETHER THEY WERE HELPFUL:

ELECTRICAL STIM	YES NO	INJECTIONS	YES NO
T.E.N.S.	YES NO	HOME EXERCISES	YES NO
ULTRASOUND	YES NO	MANIPULATION	YES NO
HOT PACKS	YES NO	ACUPUNCTURE	YES NO
COLD PACKS	YES NO		
WHIRLPOOL	YES NO		
OTHER			

ONLY MARK THE DRUGS THAT OYU HAVE PREVIOULSY TAKEN AND IF THEY HELPED:

ASPIRIN		MOTRIN		SKELAXIN	
CELEBREX		NAPROSYN		TYLENOL	
ELAVIL		NEURONTIN		ULTRAM	
FLEXERIL		PERCOCET		VICODIN	
IBUPROFEN		PRESNISONE		GABAPENTIN	
LORTAB		PROZAC		OTHER	
LYRICA		ROBAXIN			
MOBIC		SOMA			

PROSPORTS/ELITE REHAB

Review of Systems

Patient Name: _____ D.O.B.: _____

Date: _____

Please Check Each Item "Yes" Or "No"

CONSTITUTIONAL/GENERAL

WEIGHT LOSS	No ( ) Yes ( )
FEVER	No ( ) Yes ( )
CHILLS	No ( ) Yes ( )
NIGHT SWEATS	No ( ) Yes ( )
LOSS OF APPETITE	No ( ) Yes ( )
SKIN RASH	No ( ) Yes ( )

EYES/VISION

VISUAL CHANGES	No ( ) Yes ( )
CATARACTS	No ( ) Yes ( )
GLAUCOMA	No ( ) Yes ( )

EARS

HEARING LOSS	No ( ) Yes ( )
PAIN	No ( ) Yes ( )
RINGING	No ( ) Yes ( )
DIZZINESS/VERTIGO	No ( ) Yes ( )

NOSE

NOSE BLEEDS	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )
RUNNY NOSE	No ( ) Yes ( )
INJURY	No ( ) Yes ( )

THROAT

FREQ. SORE THROATS	No ( ) Yes ( )
DIFFICULTY SWALLOWING	No ( ) Yes ( )
HOARSENESS	No ( ) Yes ( )
FOREIGN BODY	No ( ) Yes ( )

HEART

HIGH BLOOD PRESSURE	No ( ) Yes ( )
CHEST PAIN	No ( ) Yes ( )
IRREGULAR HEART BEAT	No ( ) Yes ( )
PREVIOUS HEART ATTACK	No ( ) Yes ( )

LUNGS

BRONCHITIS	No ( ) Yes ( )
ASTHMA/WHEEZING	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )

Other past medical history not mentioned

_____

GASTROINTESTINAL

INDIGESTION/HEARTBURN	No ( ) Yes ( )
ULCERS	No ( ) Yes ( )
GALLBLADDER	No ( ) Yes ( )
DIARRHEA	No ( ) Yes ( )
DIVERTICULITIS	No ( ) Yes ( )
NAUSEA/VOMITING	No ( ) Yes ( )

URINARY TRACT

KIDNEY PROBLEMS	No ( ) Yes ( )
PAINFUL URINATION	No ( ) Yes ( )
BLOOD IN URINE	No ( ) Yes ( )
PROSTATE PROBLEMS	No ( ) Yes ( )

MUSCULOSKELETAL

BACK PAIN	No ( ) Yes ( )
WEAKNESS	No ( ) Yes ( )
ARTHRITIS	No ( ) Yes ( )
JOINT SWELLING	No ( ) Yes ( )
JOINT PAIN	No ( ) Yes ( )
LIMITATION of MOTION	No ( ) Yes ( )

NEURO/PSYCHOLOGICAL

NUMBNESS	No ( ) Yes ( )
MIGRAINES	No ( ) Yes ( )
SEIZURES	No ( ) Yes ( )
CONVULSIONS	No ( ) Yes ( )
STROKE	No ( ) Yes ( )
DEPRESSION	No ( ) Yes ( )

ENDOCRINE

THYROID DISORDERS	No ( ) Yes ( )
DIABETES	No ( ) Yes ( )
MENOPAUSE	No ( ) Yes ( )
HORMONE REPLACEMENT	No ( ) Yes ( )

BLOOD DISORDERS

LOW BLOOD COUNTS	No ( ) Yes ( )
BLOOD CLOTS	No ( ) Yes ( )
HEPATITIS	No ( ) Yes ( )
HIV/AIDS	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

Patient Signature:

_____

Physician Signature: _____

PROSPORTS/ELITE REHAB

MEDICATION LIST

PLEASE PRINT

Patient Name: _____ D.O.B.: _____

Are You Allergic To Any Medications? :_____

Please list below **all** medications that you are taking, include prescribed, supplements, herbals, dietary, nutritional and over the counter medications.

NAME OF MEDICATION	STRENGTH (MILLIGRAMS, GRAMS)	DOSAGE (HOW MANY TIMES A DAY?)	WHO PRESCRIBED?

If You Need More Space, Please Write "See List" And Attach A List.

PROSPORTS/ELITE REHAB

Patient Name: _____ Date of Birth: _____

The following information is for your convenience and is provided to help you understand and give consent to some of our financial policy and procedures.

- Insurance co-pays, deductibles, and any co-insurance are due at the time that services are rendered. If payment is not received, there will be a $15.00 administrative fee added to your balance. If we do not participate with your insurance company, payment is due in full at the time services are rendered. Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the initial $15.00 administrative fee for balances not paid in full at the time services are rendered. **If a minor, whomever signs the paperwork is ultimately responsible for all outstanding balances.**

- There will be a $25.00 fee for all returned checks. We can file your insurance as a courtesy.

- **Medicare Patients-** If you are a Medicare member, you will be responsible to sign and review the Advanced Beneficiary Notice (ABN), for services non-covered or deemed not Medically Necessary by Medicare. If the patient has no secondary insurance you will be responsible for the 20% co-insurance. We do not participate with any HMO policies. It is your responsibility to know your policy and if we participate with your Medicare Advantage plan.

- **Other entities**- During your course of treatment, you may be referred to other institutions for treatment. These referrals are based on solely medical necessity and our affiliations with these institutions are based on providing our patients with the highest quality and medical care possible. ProSports/Elite Rehab will make every effort in sending you to a participating facility through your insurance company, but it is ultimately the patients' responsibility. At your request we can provide other entities for your treatment. The centers you may be referred to that we have affiliations with are:

  Elite Therapy
  Elite Rehab Electro diagnostic testing
  Peter G. Wernicki, MD, PA

- Prescription refills will be addressed within 24-48 hours of request. Please check with your pharmacy prior to calling the office to see if your prescription has been received. Prescriptions will **NOT** be called in after 5:00 pm Monday-Thursday and Friday after 3:30 pm or on weekends.

- ProSports/Elite Rehab takes pride in improving your health record. We receive your last 13 months of medication history for medications prescribed to you through electronic processing. It will not include every medication you take. ProSports/Elite Rehab will submit any medications electronically that is authorized. I understand and agree that my medication history may be requested from other healthcare providers or third party pharmacies and used for treatment purposes. If you have provided an email address we will send a secured link to a website for your review of the clinical summary from your visit with ProSports/Elite Rehab.

- ProSports/Elite Rehab require necessary paperwork, diagnostic testing film and results. Without such paperwork, your appointment may need to be rescheduled. If you are late for an appointment, we may need to reschedule you to accommodate patients who are on time for their appointments.

- There is a $20.00 charge for any disability or insurance forms that need to be completed. Please allow (7) seven days for the paperwork to be completed. Payment is required prior to forms being completed.

- When copies of X-Rays/ or medical records are needed, we require a 24-48 hour notice. If your MRI needs to be filmed we require (5) working days. There is a fee of $20.00 to transfer/ film MRI or X-Rays to CDs and a $1.00 per page for copying medical records.

Your signature below acknowledges that you understand all of the above policies and procedures.

_____ _____

Patient/Parent/Guardian Signature Date

PROSPORTS/ELITE REHAB

INSURANCE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Patient/Insurance Signature Authorization
Medicare and All Other Insurance

I consent to treatment necessary for the care of the above named patient.

I authorize Peter G. Wernicki, M.D, M. Christopher Talley, M.D., Pro Sports, Marcus J. Malone, M.D., and Elite Rehab to appeal any claims on my behalf to my insurance company.

I authorize the release of my medical records to the referring/family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as necessary function of their role.

I request that payment of authorized Medicare benefits and/or any other insurance carrier benefits be made on my behalf to Peter G. Wernicki, M.D., M. Christopher Talley, M.D., Pro Sports, Marcus J. Malone, M.D., and Elite Rehab. The Medicare provider agrees to accept the Medicare assignment and the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization is to be a continued one, remaining in force until revoked in writing by the undersigned.

I acknowledge full financial responsibility for services rendered by ProSports & Elite Rehab and understand I am responsible to notify this office of any insurance changes and I have been advised that payment is due at the time of service. We do not accept any HMO plan. We are happy to submit claims for you, but ultimately the patient is responsible for payment for any charges incurred.

I understand that payment of the charges incurred, including copays, deductibles, or co-insurance is due at the time services are rendered unless prior financial arrangements have been made with our management. Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the initial $15.00 administrative fee for balances not paid in full at the time services are rendered.

If I default on my account, I agree to pay all reasonable attorney fees, interest on account, and collections costs. The collection fees are 32% for current outstanding balances and 50% for balances greater than one year.

I have read and fully understand the above and I consent to treatment, financial responsibility, release of medical information, and insurance authorization.

Patient Name:_____DOB:_____

Patient Or Parent/Guardian Signature _____ Date: _____

ProSports / Elite Rehab
Notice of Privacy Practices

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.

ProSports & Elite Rehab are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. The terms of the privacy practices are to provide you with notice of its legal duties and privacy practices regarding your health information.
ProSports & Elite Rehab reserve the right to change our privacy practices (PHI) and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes.
ProSports & Elite Rehab may use or disclose as needed, your PHI to medical students that shadow the physicians for training. We may use a sign-in sheet at the registration desk for you to indicate your name and physician you are seeing. We may call you by name in the waiting room. We may leave a voicemail on your phone, unless otherwise notified by the patient, in case of any changes to your appointment.

I acknowledge receipt of the Pro Sports & Elite Rehab Notice of Privacy Practices. I understand that, by reading this consent form and signing, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatments, payment activities and healthcare operations.

_____ _____
Printed Name ID Number or SSN

_____ _____
Signature Date of Notification

You may notify me of or my listed parties below of test results, appointment reminder, and other information regarding my health information to the phone numbers provided.

_____ Message on answering machine

_____ Message on voicemail/cell phone

Below please list the people that we are allowed to release/discuss your information to:

Name (please print) Relationship to patient

1._____ _____

2._____ _____

3._____ _____