PATIENT CONSENT AND RELEASE

FOR _____
(Patient's Full Name)

I hereby authorize treatment by Spokane Sports and Physical Therapy for the above mentioned patient. **I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor & Industry claims.** I understand that the parent accompanying a minor for treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company or attorney and authorize payment directly to Spokane Sports and Physical Therapy.

Cancellations must be made by 12:00 the day prior to the scheduled appointment.

Many insurance companies do not consider supplies a covered benefit. We will try and bill for you, but you may be asked to pay at the time of service if it is for a supply we know is not a covered benefit. Medicare will not cover many durable medical equipment supplies, such as orthotics, and you will be required to pay 50% of the cost upon casting.

As a courtesy, we will bill your insurance for you if we are given a copy of your card and all the information we need to do so. Your insurance is a contract between you, your employer and your insurance company. **We are not a party to that contract, therefore, it is the patient's responsibility to determine if there is coverage for the services being rendered, obtain prior authorization if necessary, and follow-up with unpaid visits if necessary.**

All co-payments are due on the day of treatment per our contract with the insurance companies.

If you are involved with third party litigation, arrangements can be made with the business manager before any further appointments.

PATIENT/PARENTS SIGNATURE _____

DATE _____

SPOKANE SPORTS AND PHYSICAL THERAPY

Craig L. Stephens, PT **W. Michael Stobie, PT, DPT** **Richard D. Mocabee, MAPT**

PATIENT INFORMATION

Patient Name_____
(Last) (First) (MI)

Address_____
(Street) (City) (State) (Zip)

Birth Date_____ **Age**_____ **Male/Female**

Social Security Number_____

Home Phone (___) _____

Employer_____

Address_____

Work Phone_____

Referring Physician_____

Primary Physician_____

Marital status: *Married Single Divorced Significant Other Widow/Widower*

Name of Spouse/SO_____

Emergency Contact_____

Relationship to Patient: *Spouse Family Friend Significant Other Parent/Guardian*

Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Policy/Claim Number_____

Group Number_____

Employer_____

Secondary Insurance_____

Subscriber Name_____

Subscriber DOB_____

Policy/Claim Number_____

Group Number_____

Employer_____

CONDITION/INJURY INFORMATION

WORK_____ _____
(Date of Injury) (Date of Surgery)

HOME_____ _____
(Date of Injury) (Date of Surgery)

AUTO_____ _____
(Date of Accident) (Date of Surgery)

SPORTS_____ _____
(Date of Injury) (Date of Surgery)

OTHER_____ _____
(Date of Injury) (Date of Surgery)

_____
ICD 9 #

MEDICARE PATIENTS:

Date of the Last Visit to your Doctor: _____

_____
Patient Signature

_____
Patient Initials Date

NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY AND THEN SIGN BELOW:

- If you are involved in a third party litigation, any law firm involved in the case may request copies of any and all chart notes, reports and billing statements within our possession. We must receive a signed consent from you to release this information.
- Your insurance company may request copies of any and all chart notes, reports and billing statements within our possession.
- We may send your referring Doctor, Primary Care Physician, Vocational Rehab Counselor, Nurse Case Manager and L&I Claims Manager any and all initial evaluations, progress notes, lift assessments, and discharge summaries so that they are kept appraised of your progress and to authorize continued physical therapy.
- We may use your personal information to obtain a referral authorization from your Primary Care Physician or Specialist so that your insurance company will cover the cost of your treatment.
- We may release your personal information to our contracted billing service, CMSI, so that they may assist us in billing your insurance company for the services provided by this office.
- We may use your information to verify benefits, co-payment amounts and billing information with your insurance company.
- You are entitled to a copy of any and all chart notes, reports and billing statements within our possession and may request them at any time. We must have a signed release from you signed within the previous 30 days to release this information.
- You are entitled to request any and all names of companies and individuals that have requested your information from this office.

By signing below, I acknowledge that I have read and understand how my Personal Health Information may be used and disclosed by Spokane Sports and Physical Therapy.

Signature_____ Date____ /_____/_____

Spokane Sports and Physical Therapy
HISTORY AND INTERVIEW

Patient Name:_____ **Date:**_____

1. **HOW** did your problem begin?_____

_____

2. Do you have an injury due to a recent fall? □ Yes □ No
3. **WHAT** are your primary complaints?_____
4. Past/present treatments for this condition:_____

   Previous physical therapy: □ Yes □ No When: _____ How many visits:_____

5. Do you have, or have you had any of the following?

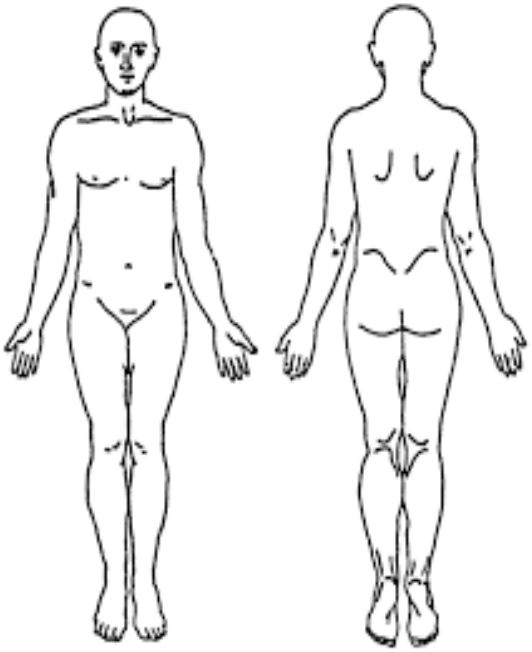
□ Diabetes
□ Chest pain / Angina
□ High Blood Pressure
□ Heart Attack
□ Pacemaker
□ Kidney Problems
□ Cancer
□ Osteoporosis
□ Asthma
□ Liver / Gallbladder Problems
□ Stroke / CVA
□ Hernia
□ Seizures
□ Recent Fractures
□ Nausea / Vomiting
□ Rheumatoid Arthritis
□ Hypoglycemia
Other_____

6. Please list all Medications:_____

_____

7. Make a mark (-) along the line to the right from extremes "No Pain At All" and "Pain As Bad As It Could Be", indicating your current pain level in your major area of injury. ►

The Worst Imaginable Pain



No pain

8. Have you had similar problems in the past? □ Yes □ No

   If so, please explain:_____
9. What is your occupation/hobbies?_____
10. Are you currently working? □ Yes □ No
    If not, is it due to your condition? □ Yes □ No
11. Just prior to the onset were you completely free of symptoms
    □ Yes □ No
12. Does anything make your pain **worse?** □ Yes □ No
    If so, what?_____

    _____
13. Does anything ease your pain? □ Yes □ No
    If so, what?_____

    _____
14. Are you able to get comfortable at night?
    □ Yes □ No
15. How do you feel upon rising in the morning?
    □ Stiff □ Sore □ Fine
16. Once you start moving about does it
    □ Worsen □ Ease
17. What is it like at the end of the day?
    □ Better □ Worse □ No Change
18. At this time, do you feel that you are getting? □ Better □ Worse □ No Change
19. Comments:_____

    _____