RENO SPORT & SPINE INSTITUTE
SIDENER PHYSICAL THERAPY, LLC

15 McCabe Drive, Suite 101 • Reno, Nevada 89511 (775) 788-5599 • Fax (775) 788-5598

Today's date: _____ Patient Name: _____

Date of Birth: _____ Age: _____ Height _____ Weight_____

Referring Physician: _____ Date of Last MD Exam: _____ Date of Injury (if applicable):_____

How did injury occur? _____

List other treatment received for this injury (include therapy, chiropractic care, labs, MRI, x-ray, special exams, surgery, and/or second opinions): _____

Describe your symptoms (what you're feeling): _____

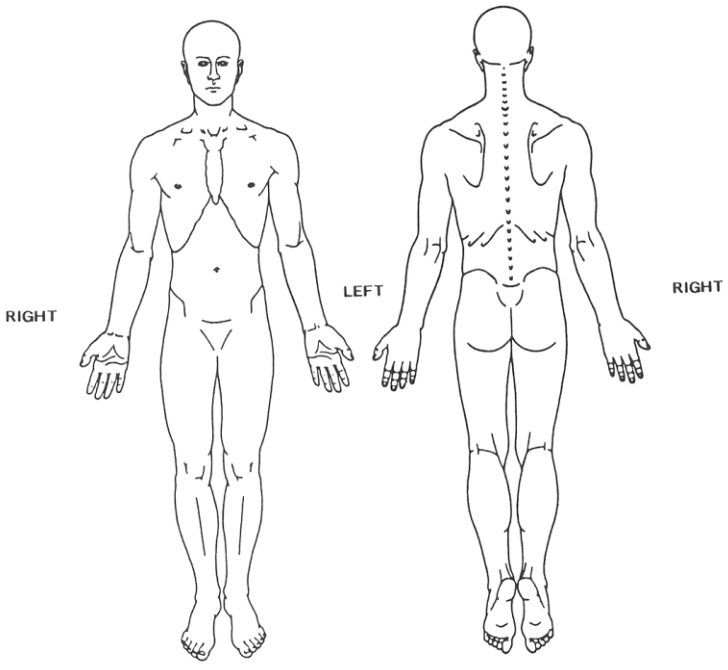
Using the following Pain Level Scale, rate your pain.

LOW		MODERATE			SEVERE			EMERGENCY	
0	1	2	3	4	5	6	7	8	9	10

What is your pain level right now? _____

The best in the past day? _____ The worst in the past day? _____

Please use the following diagram to show: XXX = PAIN OOO = NUMBNESS /// = TINGLING



Medical History Name: _____ DOB:_____ Date:_____

Existing or Relevant Previous Conditions:

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

If "Yes" to Any of the above, explain and give approx. dates. Describe any MEDICAL PRECAUTIONS/ CONDITIONS:

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?

Surgical History, most recent first*

Body Region: _____Surgery Type: _____ Date: _____/_____/_____

Body Region: _____Surgery Type: _____Date: _____/_____/_____

Additional Surgeries:_____

Current Medications (including over the counter, vitamins and/or supplements)*

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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☐ **Currently not taking any medications** ***Can continue on back of page if needed**

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PATIENT INFORMATION

Name: _____ Today's Date: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (Circle One) Hm / Cell (____) _____(wk) (____) _____

Send appointment reminders via Text / Email (Circle One) E-Mail Address: _____

Sex: M____ F_____ Birth Date: _____ Marital Status: _____ Social Security #_____

Occupation: _____ Employer: _____

Spouse/Parent/Guardian's Name: __ _____ Hm/Cell #: _____ Wk #: _____

Person responsible for account (*If different than patient*): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Nearest Relative not living with you: _____Phone #: (___) _____

Nearest Friend not living with you: _____ Phone #: (___) _____

Referring Physician: _____

Name of any other provider you are under active care with_____

Whom may we thank for this referral? _____

Have you had any Therapy (Physical, Occupational or Speech) this year or within your plan year? □ Yes □ No

When: _____Where:_____ How Many Visits: _____

MEDICARE INFORMATION

MEDICARE PATIENTS: Have you been or are you enrolled in Home Health? □ Yes □ No

If Yes: When_____ Discharge Date _____

Are you: Disabled □ Retired □ Still Working □ **Is Medicare secondary to a working spouse? □ Yes □ No**

ACCIDENT INSURANCE INFORMATION

Is Current Injury **WORK** Related? □ **Yes** □ **No** **Date of Injury**? _____

Is Current Injury **AUTO** Related? □ **Yes** □ **No** **Date of Injury**? _____

Claim #:_____ Adjuster/Case Manager _____ Phone #: (___)_____

In what state did accident occur? _____ Have you retained an Attorney? □ Yes □ No

If yes, Name of Attorney/Firm/ Phone Number #: _____

OTHER INSURANCE INFORMATION

Primary Insurance Company: _____ Policyholder's Name (*If different than patient*): _____

Date of Birth_____ ID #: _____ Group #: _____ Insured's Social Security #: _____

Relationship to Patient: _____ Mailing Address (*If different than patient*):_____

Secondary Insurance Company: _____ Policyholder's Name (*If different than patient*): _____

Date of Birth_____ ID #: _____ Group #: _____ Insured's Social Security #: _____

Relationship to Patient: _____ Mailing Address (*If different than patient*):_____

Do you have a third (Tertiary) Insurance? Name_____ ID#_____

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ASSIGNMENT OF BENEFITS AND RELEASE

1. Consent for Treatment
By signing this form, I consent and authorize physical therapy. I understand that my provider is available to me to explain the treatment and I have the right to refuse.

2. Professional Service Insurance Release & Assignment of Benefits
I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case. I authorize the release of information by my physician and/or x-ray or imaging company that is pertinent to my care. I also authorize payment of any benefits be paid directly to Sidener Physical Therapy LLC, for services provided to my dependents or me. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible on remaining balances should my insurance carrier determine the services I received are not covered.

3. Insurance
I understand Sidener Physical Therapy LLC will bill any insurance company that they currently hold a contract with. However, insurance coverage is a contract between myself and my insurance carrier. It is my responsibility to know my personal benefits. Insurance benefits quoted to Sidener Physical Therapy LLC are not always a guarantee of payment. If I am a part of an HMO plan, it is my responsibility to make sure my treatment is authorized. If my treatment is unauthorized, I will be responsible for the full amount of your charges. Sidener Physical Therapy LLC will not become involved in any disputes between me and my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary.

Please note:

Sidener Physical Therapy LLC is not a provider for Medicaid; therefore, we are unable to bill for this benefit and you will be financially responsible.

Sidener Physical Therapy is not contracted with Blue Cross/Blue Shield or Anthem plans. If this is your primary or secondary insurance you will be responsible for all charges.

4. Referrals and Authorizations
I understand that if my insurance requires a referral from my PCP or Specialist for therapy services and I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, it will be my responsibility to contact my PCP or Specialist's office the same day and obtain the necessary referral or authorization, dated for the date of the service. I also accept full financial responsibility for all charges incurred for services received on the day of service, if my insurance company denies the claim(s) for lack of referral or authorization.

5. Payment
I accept financial responsibility for payments for all services and products received. All co-payments, deductibles, and co-insurances are due at the time of service. I also understand there will be an additional $35.00 processing fee for all returned checks. **If you believe you have overpaid us please contact our financial department before you contact your Bank or Credit Card Company.**

6. Self-payment
If you opt for self-pay status and we hold a contract with your insurance company you may not, under any circumstances, submit those bills to your insurance company for reimbursement.

7. Durable Medical Equipment (DME)
Our office sells DME at almost cost value as a benefit to help our patients with their treatment. This is not reimbursable with your insurance through Sidener Physical Therapy LLC. If you would like your insurance to pay for it you must use the company that your insurance holds a contract with.

8. Collections
If your account is 90 days past due it is subject to be turned over to a collection agency. All fees that we incur to secure past due balances will be charged to your account. Currently we are charged **66%** of all balances collected. This means that in addition to your past due balances, **66%** of that balance will be charged to your account and sent to collections as well.

9. Missed appointments
Missed appointments or appointments cancelled less than 24 hours in advance, may be charged at the rate of a normal office visit: $85.00.

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10. Assignment of Benefits

I, the undersign, certify that I (or my dependent) assign directly to Sidener Physical Therapy, LLC/ Reno Sport and Spine Institute all insurance benefits, if any, other payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by the insurance company. I authorize the use of this signature for submission of insurance claims. All checks and payments are to be made out to:

Sidener Physical Therapy, LLC
15 McCabe Drive, Suite 101
Reno, NV 89511

A photocopy of this assignment shall be considered as effective and valid as the original.
I authorize Sidener Physical Therapy LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
By signing below, I attest I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Patient name (please print) _____

Patient Guardian (if under 18) _____

Signature _____

Date: _____

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Sidener Physical Therapy Notice of Privacy Practices

THIS NOTICE IS A BRIEF DESCRIPTION OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO INFORMS YOU OF HOW TO OBTAIN THIS INFORMATION YOURSELF.

-If you would like a copy of our policy, in its entirety, please contact our office manager. -

Our obligation:

By law, we are required to:

- Maintain the privacy of protected Health Information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our current policy that is in effect.

How We May Use and Disclose Health Information:

The following are reasons for us to utilize and disclose your Health Information: treatment, payment, health care operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved in your care or payment of your care, and research. We will utilize this information only with your written permission. You may revoke this agreement at any time by writing to our office manager.

Special Situations:

There are certain situations that require us to utilize your Health Information. These include as required by law and/or to avert a serious threat to health or safety. We may also disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Your Rights:

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

Changes to This Notice:

We reserve the right to change this notice and make the new notice apply to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice in the reception area of our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary or the Department of Health and Human Services. To file a complaint with our office, contact our office manager. All complaints must be made in writing. ***You will not be penalized for filing a complaint.***

Please advise us on the best way to contact you (8-5): ____Work ____ Home ____ Cell

A message can be left regarding medical treatment at: _____Work _____Home _____Cell Please do not leave a message: _____

Our current policy is that we give information only to you regarding your medical treatment. If you want to give permission to discuss protected information with other family members, please note (circle) and initial.

Yes No Spouse: _____Medical issues Billing/Insurance _____
Name (initial)

Yes No Other: _____Medical issues Billing/Insurance_____
Name (initial)

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

Patient Signature_____ Date_____

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WORKERS' COMPENSATION INFORMATION
TO BE FILLED OUT BY INJURED WORKER: (ALL FIELDS REQUIRED)

Injured Worker's Name: _____ Date of Injury: _____/_____/_____

SS #: _____-_____-_____ Claim #: _____

Employer **(AT TIME OF INJURY)**_____

Employer Address: _____

Employer Phone: (_____) _____-_____

WORKERS' COMPENSATION CARRIER / ATTORNEY INFORMATION

Carrier: _____

Claims Mailing Address: _____

Adjuster's Name: _____

Phone: (_____) _____-_____ Extension: _____ Fax: (_____) _____-_____

Utilization Review or Nurse Case Manager Contact: _____

Phone: (_____) _____-_____ Extension: _____ Fax: (_____) _____-_____

Attorney Name: _____ Phone: (_____) _____-_____

Mailing Address: _____

NON-COMPLIANCE NOTIFICATION

Your therapist, physician, adjuster and case manager work together to assist with your return to full function in the workplace. In order for your treatment to have maximal effect and progress, all prescribed therapy sessions must be attended. To comply with the workers' compensation laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call in a timely manner and we will reschedule your appointment and inform your adjuster. Missed appointments may result in discontinuation of workman's compensation benefits.

FINANCIAL POLICY

In the event, that my Work Comp claim is denied by the Workers' Compensation Carrier, Sidener Physical Therapy, LLC will not transfer charges to an attorney lien that were assessed prior to the date the claim was denied. I understand and agree that I become the responsible party and liable for payment of all charges assessed for professional services rendered. I agree to pay any sum due, upon demand. I understand and agree that if it becomes necessary for Sidener Physical Therapy, LLC to utilize an outside collection agency, for the collection of any outstanding charges, I will be responsible for the outstanding balance plus 66% of that balance will be charged to my account and sent to collections as well. I have read and understand the non-compliance notification and financial policy. I do hereby acknowledge that all information on this form is true and factual.

Patient Signature: _____ Date: _____