

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: _____ (FOR OFFICE USE ONLY: 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): _____

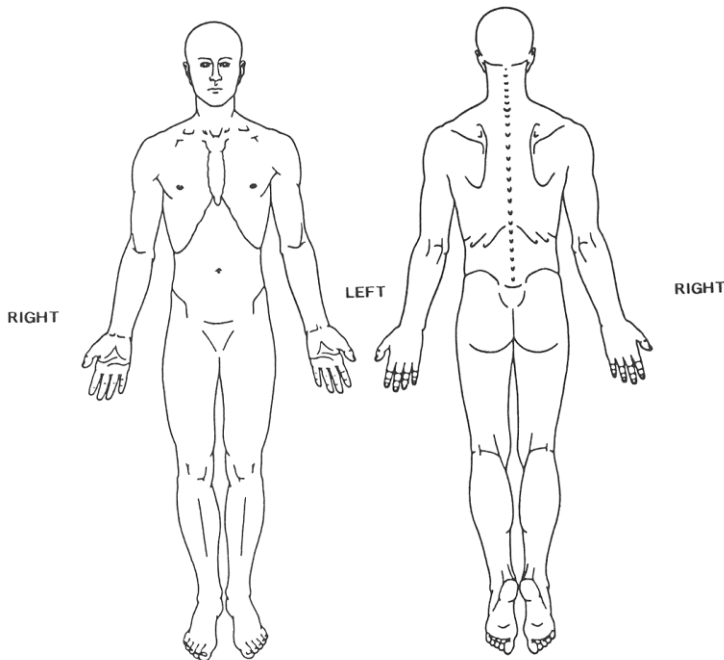
Using the following Pain Level Scale, rate your pain.

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

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

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.

Page 1 of 2 please initial _____

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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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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: _____