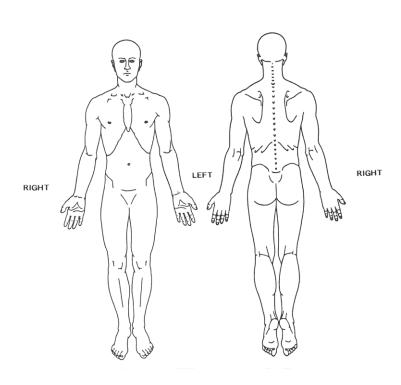


15 McCabe Drive, Suite 101 • Reno, Nevada 89511			(775) 788-5599 • Fax (775) 788-5598		
Today's date:	Patient Name:				
Date of Birth:	Age:	(FOR OFFICE US	E ONLY: Height:	Weight:)	
Referring Physician:	Da	te of Last MD Exam:	Date of Injury (if	applicable):	
How did injury occur?					
List other treatment received and/or second opinions):			· -	pecial exams, surgery,	
Describe your symptoms (wh	at you're feeling):	:			
Using the following Pain Lev	el Scale, rate your	r pain.			
	LOW MC 0 1 2	ODERATE SEVERE 1	EMERGENCY 8 9 10		
What is your pain level right	now?				
The best in the past day?	The v	worst in the past day?			
Please use the following diag	ram to show: XX	X = PAIN $OOO = NUN$	MBNESS /// = TINGLI	ING	



Medical History	Name:		DOB:	Date:	Date:	
Existing or Relevant Previous Conditions:						
Allergies	○ Yes ○ No	Diabetes	○ Yes ○ No	Metal Implants	○ Yes ○ No	
Anemia	○ Yes ○ No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No	
Anxiety	○ Yes ○ No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No	
Arthritis	○ Yes ○ No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No	
Asthma	○ Yes ○ No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No	
Autoimmune Disorder	○ Yes ○ No	Gallbladder Problems	○ Yes ○ No	Parkinson's	○ Yes ○ No	
Cancer	○ Yes ○ No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No	
Cardiac Conditions	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No	
Cardiac Pacemaker	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No	
Chemical Dependency	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Speech Problems	○ Yes ○ No	
Circulation Problems	○ Yes ○ No	High/Low blood pressure	Yes () No	Strokes	○ Yes ○ No	
Covid-19	○ 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	
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	e: Reason T	aking:	
Drug:	Dosage: _	Frequency: _	Route	e: Reason T	aking:	
Drug:	Dosage: _	Frequency: _	Route	e: Reason T	aking:	
Drug:	Dosage: _	Frequency: _	Route	e: Reason T	aking:	
Drug:	Dosage:	Frequency	: Rout	e: Reason T	aking:	

☐ Currently not taking any medications

*Can continue on back of page if needed

RENO SPORT & SPINE INSTITUTE

SIDENER PHYSICAL THERAPY, LLC
PATIENT INFORMATION

Name:	 			Today's Dat	te:
		First Name	MI		
Address:			City:	State:	Zip Code:
Phone #: (Circle	e One) Hm / Cell ()	((wk) ()	
Send appointme	ent reminders via Text /	Email (Circle On	e) E-Mail Addr	ess:	
Sex: M F_	Birth Date:	Mar	ital Status:	Social Security	#
Occupation:		F	Employer:		
Spouse/Parent/C	Guardian's Name:		Hm/Ce	11 #:	Wk #:
Person responsi	ble for account (If differ	rent than patient):			
Address:			City:	State:	Zip Code:
Emergency Co	ntact Information				
Nearest Relative	e not living with you: _			Phone #: (_)
Nearest Friend	not living with you:			Phone #: (_)
Referring Physi	cian:				
Name of any oth	her provider you are un	der active care wi	th		
Whom may we	thank for this referral?				
Have you had a	any Therapy (Physical	, Occupational o	r Speech) this	year or within your	plan year? Yes No
When:	Wh	iere:		I-	How Many Visits:
		MEDICAR	E INFORMAT	TION	
MEDICARE P	PATIENTS: Have you	been or are you	enrolled in Ho	me Health? Yes	□ No
If Yes:	When		Discharge D	Oate	
Are you: Disab	oled Retired Still	Working \square	Is Medica	are secondary to a v	vorking spouse? Yes
	\mathbf{A}	CCIDENT INSU	RANCE INFO	ORMATION	
Is Current Injur	y WORK Related?	Yes □ No Date	of Injury?		
Is Current Injur	y AUTO Related? \square Y	es 🗆 No Date	of Injury?		_
Claim #:	Adjus	ter/Case Manager		F	Phone #: ()
In what state did	d accident occur?	Have y	ou retained an	Attorney? ☐ Yes ☐	No
If yes, Name of	Attorney/Firm/ Phone	Number #:			
		OTHER INSUR	ANCE INFOR	RMATION	
Primary Insur	ance Company:	Polic	cyholder's Nam	e (If different than p	atient):
Date of Birth	ID #:	Gr	oup #:	Insured's Soci	al Security #:
Relationship to	Patient:	Mailing Addı	ess (If different	than patient):	
Secondary Inst	urance Company:	Pol	icyholder's Nar	me (<i>If different than</i> p	patient):
Date of Birth	ID #:	Gr	oup #:	Insured's Soci	al Security #:
Relationship to	Patient:	Mailing Addı	ess (If different	than patient):	
Do you have a	third (Tertiary) Insur	ance? 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.

ient name (please print)	
iont Cuardian (if under 19)	
cient Guardian (if under 18)	
gnature	
te:	



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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 co	ntact you (8-5):	Work Home	Cell	
A message can be left regarding medica	al treatment at:W	orkHome	Cell	Please do not leave a message:
Our current policy is that we give information with other family		· ·	treatment.	If you want to give permission to discuss
Yes No Spouse:Name	Medical issue	s Billing/Insuran	ce(initial)	
Yes No Other:Name	Medical issues	s Billing/Insuran	ce(initial)	-
By signing below you understand and a	re in agreement with this	s Privacy Policy.		
Patient Signature			Da	ite



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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 CAR	RIER / ATTORNEY INFORMATION
Carrier:	
Adjuster's Name:	
	Extension: Fax: ()
Utilization Review or Nurse Case Manage	er Contact:
Phone: ()	Extension: Fax: ()
Attorney Name:	Phone: ()
Mailing Address:	
	NON-COMPLIANCE NOTIFICATION
Your therapist, physician, adjuster and car	se manager work together to assist with your return to full function in the workplace.
In order for your treatment to have maxing	nal 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 u	nable to attend, please call in a timely manner and we will reschedule your
appointment and inform your adjuster. M	issed appointments may result in discontinuation of workman's compensation
benefits.	
	FINANCIAL POLICY
In the event, that my Work Comp claim is	s denied by the Workers' Compensation Carrier, Sidener Physical Therapy, LLC will
not transfer charges to an attorney lien that	at were assessed prior to the date the claim was denied. I understand and agree that I
become the responsible party and liable for	or 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 colle	ction 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 poli	cy. I do hereby acknowledge that all information on this form is true and factual.
Patient Signature:	Date: