PATIENT INFORMATION

Today's Date:_____ **(PLEASE PRINT)** **Soc. Sec.#**_____-_____-_____

Name:_____ **Nick Name**_____
First Middle Last

Sex: M F Birth date:_____ **Age:** ____ **Current Student Grade Level:** ____ **Full Time / Part time** (Circle One) **Single / Married** (Circle One)

Patient Employed by: _____ **Occupation:**_____

Employers Address: _____ **Employers Phone Number: ( ) _____- _____**

Address:_____**City:**_____ **State:**_____ **Zip:**_____

Home Number: ( ) _____- _____ Mobile Number: ( ) _____-_____ Email:_____

Preferred method of communication: Home Number ___ Mobile Number ___ eMail ___

In case of emergency who should be notified?_____ _____ **Phone: ( ) _____- _____**
Name Relation to Patient

Date Symptoms Began: _____ **Chief Complaint:**_____

****Did this injury occur as a result of a car accident? If so, when did the accident occur?**_____

What caused your symptoms? _____

Referring Physicians Name:_____ **Date to return to Physician:** _____/_____/_____

How did you hear about Boost Physical Therapy & Sports Performance?_____

Have you had any previous physical therapy for this injury? _____

INSURANCE POLICY HOLDER

Self _____ **(if "yes" - skip to next section)**
Y/N

_____ _____ **Phone: ( ) _____- _____**
Name Relation to Patient

Address: _____**City:**_____ **State:**_____ **Zip:** _____

Soc. Sec.#_____-_____-_____ **Birth date:**_____

PRIMARY INSURANCE

Name of Insurance Company _____**Group#**_____ **ID#**_____

SECONDARY INSURANCE

Name of Insurance Company _____ **Group#**_____ **ID#**_____

Office Use Only

Collect $50/visit towards Deductible: _____
Yes / No

PRIMARY: Visit Limits: _____ **Used:** _____ **Policy Dates:** _____ **Co-Pay:** _____ **Co-Insurance Ratio:** _____

Deductible: _____ **Met:** _____ **Out of Pocket Max:** _____ **Met:** _____ **Authorization Required:** _____

Family Ded:_____ **Met:** _____ **Family Out of Pocket:** _____ **Met:** _____ **Months of the Policy Year:** _____

SECONDARY: Do they recognize the Primary Carrier: _____

MEDICARE: Visits Used: _____ **Deductible Met:** _____ **Effective Date:** _____ **Is Medicare Primary:** _____

Do they have Medicare HMO: _____ **Is there supplemental insurance:** _____ **Are they currently using Home Health:** _____

SIGNATURE: _____ **DATE:**_____

General Medical Form

Name: _____ Date: _____

Briefly describe your condition _____
_____

When did your condition begin? _____

When was your most recent doctor's appointment? _____

Is your condition a result of an event such as a fall or car accident? Yes No

Is your condition resulting in a workmen's compensation claim? Yes No

If yes for either, please explain. _____
_____ Is a lawyer involved? Yes No

Have you had this condition in the past? Yes No

Have you had any other treatment for this condition (currently or in the past) Yes No

If yes, please check:

___Surgery	___Chiropractic care	___CT scan
___Medications	___Physical therapy	___MRI
___Injections	___X-rays	___EMG/ NCV

___Other: _____

Have you had physical therapy for this or any other condition in the last year? If so, please list approximate dates and cause for services. _____
_____

Please list all current prescription medications that you are taking for any condition. _____
_____

Please list all prior surgeries. _____

Please list all allergies. _____

What are your goals for physical therapy? _____

General Medical Form (continued)

At the present time, would you rate your overall general health as:
____excellent ____good ____fair ____poor

Please circle all conditions that you have, or have had in the past.

Musculoskeletal
Osteoarthritis
Rheumatoid Arthritis
Lupus/SLE
Fibromyalgia
Osteoporosis
Headaches/Migraines
Bulging Disc
Leg Cramps/Restless Legs
Jaw Pain/TMJ
History of falling
Use of cane or walker
Gout
Other: _____

Nervous System
Stroke/TIA
Polio
Parkinson's disease
Multiple Sclerosis
Epilepsy/Seizures
Concussion/TBI
Numbness or Tingling
Other: _____

Psychological
Depression
Anxiety disorder
Bipolar disorder
Schizophrenia
Obsessive compulsive disorder
Other: _____

Circulation/Respiratory
Heart Attack
Heart Surgery
Heart Arrhythmia
Pacemaker
High Cholesterol
Blood Clots/Phlebitis
Anemia
High Blood Pressure
Asthma/SOB
COPD
Other: _____

Skin
Skin Allergies/rashes
Eczema
Psoriasis
Other: _____

Cancer
Type of Cancer:
_____
_____
Date of Diagnosis:
_____
Treatments:
_____
_____

Endocrine/Digestion
Diabetes
Kidney Dysfunction
Irritable Bowel
Bladder Dysfunction
Liver Dysfunction
Thyroid Dysfunction
Hernia
Other: _____

Infectious Disease
TB
Hepatitis
Influenza
Shingles
Other: _____

Are you currently pregnant?
Yes No

Do you smoke?
Yes No

Patient's signature: _____ Date: _____

Parent or Guardian signature:_____ Date: _____

I have reviewed any contraindications and their rehabilitation protocol with the named patient or the appropriate caregiver prior to initiating evaluation and treatment.
Therapist's Signature: _____ Date: _____

CONSENT FOR TREATMENT

I recognize that I am suffering from a condition requiring physical therapy and/or athletic training services and treatment. I hereby consent to the rendering of services by Boost Sports Performance, LLC, as described to me or as my physician or Boost Sports Performance, LLC determines are necessary. I understand that the practice of physical therapy/athletic training is not an exact science and that treatment involves the risk of injury or even death. I acknowledge that no guarantees have been made to me about the outcome of treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign Boost Sports Performance, LLC, (1) all insurance, Medicare, and other private or governmental benefits payable for my treatments and care, and (2) all rights to payment and all money paid for any claim related to the reasons for which I am being given physical therapy/athletic training services and treatment. Anyone paying or receiving money for my benefits or claims shall pay the money directly to Boost Sports Performance, LLC, for payment of my bills. I understand that I am responsible for knowing and understanding any and all benefits provided by my insurance and that any information provided by Boost is only an estimate of those benefits.

I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that any balance after insurance or third party payment has been made is due within thirty (30) days. I understand that after thirty (30) days, I may be sent to collections and reported to credit bureaus. If I am sent to collections, I understand I will be assessed a $35 fee in addition to any balance owed.

_____

Participant Signature Date

_____

Parent or Guardian Signature Date

_____

BOOST Employee Signature Date

HIGH SCHOOL ATHLETE RELEASE

I authorize the release of any or all medical information pertaining to my condition and progress to the athletic training department at my high school.

_____ _____

Participant Signature Date Name of High School

_____

Parent or Guardian Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the Notice of Privacy Practices and make a good faith effort to obtain an acknowledgment of receipt. You may refuse to sign this acknowledgment form.

I have been provided with the Notice of Privacy Practices of Boost Physical Therapy & Sports Performance and understand that any questions or concerns regarding this notice may be directed to the Privacy Officer, Travis Neff, and concerns can be mailed to 2105 Kara Court A-1, Liberty, MO 64068, or call 816-407-1249.

By signing this form I confirm that I have reviewed a copy of the office Notice of Privacy Practices.

Print Name_____

Sign Name_____

Date_____