# WELCOME TO SPORTS CONDITIONING AND REHABILITATION

Thank you for choosing SPORTS CONDITIONING AND REHABILITATION, (SCAR) for your physical therapy needs. We know there are many other PT clinics from which to choose and appreciate your confidence in us.

You will find we provide unsurpassed individualized patient care in a warm, caring, and professional environment. SCAR's therapy team has the expertise to help you progress through the entire continuum of wellness – from relieving your pain and recovering from your injury or disability to promoting prevention of re-injury and leading a full, healthy lifestyle.

We begin our partnership by providing you with the information you need to make your physical therapy experience the best it can be. Please take time to read all of our attached policies and fill out the attached forms completely prior to your scheduled appointment. You are responsible for understanding and acknowledging all of the information contained in our policy pages.

On the day of your initial appointment, please arrive 20 minutes early and bring the following:

- Completed forms
- Medical insurance card
- Identification card (e.g., Driver's License)
- Your doctor's prescription for physical therapy, if required by your insurance plan.

Arriving before your appointment time allows our staff to review your paperwork and to collect the last few items we need from you to initiate your care. If you need to fill out your paperwork at SCAR, please allow at least 30 minutes before your scheduled appointment.

To better serve you and provide the highest quality care, please follow these guidelines:

- Upon arrival for your first and all follow up visits check in with the front desk staff.
- Before leaving, schedule your follow up appointments for your entire treatment plan prescribed by your physical therapist to ensure you get the days and times that work best.
- Please be on time. You will receive appointment reminders from us, and you can call to confirm your appointment times if you are ever uncertain.
- Please set your cell phone(s) on silent or vibrate and put in a pocket or purse.
- Dress for Exercise.
    - Be prepared to exercise and move easily by wearing loose-fitting, comfortable clothing.
    - We have locker rooms if you'd like to change, store your clothes, and/or shower. Please bring your own lock for the locker.

*We greatly appreciate your cooperation and trust*
*as we strive to accomplish wonderful results and success with you.*

# NEW PATIENT INFORMATION

Appointment Date: _____ Therapist: _____

## PATIENT INFORMATION

Name: _____

Date of Birth: _____ Marital Status: _____

Address: _____
Street

_____ _____ _____
City State Zip

Employer or
School Name: _____

Occupation: _____

Student Athlete? Yes ◯ No ◯ _____
If yes, what sport(s)?

Has the patient had home health this year? Yes ◯ No ◯

Has the patient had physical therapy this year? Yes ◯ No ◯

Date of injury: _____

Was the injury caused by an auto/vehicle accident? Yes ◯ No ◯

If yes, fault or no fault? (check one): Fault ◯ No Fault ◯

Was the injury caused at work? Yes ◯ No ◯

## RESPONSIBLE PARTY INFORMATION

Name: _____

Relationship to patient: _____

Employer: _____

Employer Address: _____

### Primary Insurance

Insurance Company: _____

Phone: _____

Guarantor: _____ Guarantor's Date of Birth: _____

Insurance ID #: _____ Group #: _____

Secondary Insurance Company (if applicable): _____ ID #: _____ Group # _____

Why did you choose SCAR? (check one):

Returning patient ☐ Physician referral ☐

Family/friend ☐ Website/online ☐

Other (explain): ☐ SCAR gym member ☐

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Appointment reminder preference (check one):

Text ◯ Email ◯ Phone ◯

## IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Were you evaluated by a physician for this injury?

Yes ◯ No ◯

## REFERRING PHYSICIAN (Who prescribed your PT?)

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

## AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

*I grant permission for all physical therapy treatment and procedures deemed necessary by my physician and/or my physical therapist.*

*I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Sports Conditioning and Rehabilitation.*

_____ _____
Patient/Guardian Signature Date

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# HEALTH HISTORY AND MEDICATIONS

SCAR Sports Conditioning and Rehabilitation
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Patient name: _____ Date: _____

To help ensure that you receive the best possible care, please provide us with this important background information. If you don't understand a question, leave the area blank, and your therapist will assist you. Thank you!

Are you currently under the care of a physician, podiatrist, chiropractor, or another physical therapist? Yes ◯ No ◯

Date of last complete physical examination: _____

If yes, please explain the reason (e.g., illness, injury): _____

Have you fallen before? (not during sports or play) Yes ◯ No ◯

If yes, were you injured? Yes ◯ No ◯

Do you smoke/use tobacco? Yes ◯ No ◯

Rate your typical stress level on a scale of 0 to 5, with 5 being extremely stressed: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

How many hours of sleep per night do you usually get? _____

How many beverages containing alcohol do you drink weekly? _____

How many caffeinated beverages do you drink daily? _____

Which best describes your regular diet? (Check ( ✓ ) one):

◯ Standard American Diet (red meat, refined carbs, etc.) ◯ Vegetarian or vegan ◯ Lean meats, veggies, fruits, whole grains ◯ Other: _____

Please list any prior surgeries, including type and month/year: _____

Please list all medications and supplements that you are currently taking

Over-the-counter medications (e.g. pain relievers, antihistamines): _____

Prescription medications: _____

Supplements, including vitamins: _____

Other health conditions might affect your treatment. Please check ( ✓ ) any of the following that apply to you previously or currently:

- ☐ Allergies (medications, foods, latex)
- ☐ Anxiety or panic disorder
- ☐ Depression
- ☐ Arthritis, rheumatoid or other reactive
- ☐ Arthritis, osteoarthritis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bleeding tendency, bruise easily
- ☐ Cancer: _____ Type

Cardiac:

- ☐ Angina
- ☐ Arrhythmia
- ☐ Pacemaker, ICD
- ☐ Heart attack (myocardial infarction)
- ☐ Heart failure
- ☐ Valve disorder or replacement
- ☐ Coughing, chronic
- ☐ Concussion or other brain injury
- ☐ COVID-19 or SARS
- ☐ Dementia
- ☐ Eating disorder
- ☐ Gastrointestinal disorder (GERD, ulcer, hernia; bowel, liver, gall bladder issues)
- ☐ Headaches
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Dizziness, lightheadedness
- ☐ Diabetes, pre-diabetes
- ☐ Kidney, bladder, urinary, prostate problems
- ☐ Lung disease (e.g. COPD, emphysema)
- ☐ Neurological disease (e.g. MS, Parkinson's)
- ☐ Osteoporosis, osteopenia
- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Prostheses or implants
- ☐ Sleep dysfunction
- ☐ Spinal problems (e.g. back/neck pain, stenosis, scoliosis, sciatica)
- ☐ Seizure disorder
- ☐ Stroke or TIA
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Vision impairment (e.g. cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment
- ☐ Weight loss, recent unintended

Other: _____

I have fully and accurately completed this form. I understand that providing inaccurate or incomplete information could negatively impact my health. It is my responsibility to inform my physical therapist of any changes to my medications and/or health status.

Patient/Guardian Signature: _____

# CURRENT INJURY INFORMATION

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Patient name: _____ Date: _____

To help ensure that you receive the best possible care, please provide this important information regarding your current injury.
If you don't understand a question, leave the area blank, and your therapist will assist you. Thank you!

Injury location (affected body part).
Please include left or right if applicable: _____

Date of injury or
onset of symptoms: _____

Describe how your injury occurred
or how your symptoms began: _____

Have you been evaluated by
a physician for this injury? Yes ◯ No ◯

Date of your next physician
appointment for this injury: _____

Dates and types of surgeries, injections and/or
other procedures you've had for this injury: _____

Previous history of similar
injury or symptoms? Yes ◯ No ◯

If yes, did you have PT? Yes ◯ No ◯

## Functional Status

What was your activity level prior to this injury? Sedentary ◯ Light ◯ Moderate ◯ High/Athletic ◯

What activities are you not able to do now due to injury?

☐ Work/School without modifications ☐ Household chores ☐ Regular exercise, training routines ☐ Lifting objects ☐ Stairs, up/down
☐ Bending or reaching ☐ Gardening ☐ Sports Other: _____

## Pain and Other Symptoms

Rate your pain level on a scale of 0 to 10, with 0 being no pain and 10 being the worst imaginable pain:

| ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 | ◯ 5 | ◯ 6 | ◯ 7 | ◯ 8 | ◯ 9 | ◯ 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No pain | Mild pain | | | Moderate pain | | | Severe Pain | | | |

Which describe(s) your pain? Please check ( ✓ ) any of the following that you are experiencing:

☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy ☐ Burning ☐ Radiating ("shooting")

Is your injury causing other symptoms? Please check ( ✓ ) any of the following that you are experiencing:

☐ Numbness or tingling ☐ Loss of motion ☐ Swelling
☐ Redness or bruising ☐ Loss of strength ☐ Muscle spasm or cramping
☐ Night pain, difficulty sleeping ☐ Clicking, snapping, "crunching" with motion ☐ Trigger points (painful "knots")

Other: _____

What, if anything, relieves or lessens your pain? ☐ Resting ☐ Motion ☐ Sitting ☐ Standing ☐ Walking ☐ Better in the a.m. ☐ Better in the p.m.
☐ Medication ☐ Supplement (e.g. CBD) Other: _____

What makes your pain worse? ☐ Resting ☐ Motion ☐ Sitting ☐ Standing ☐ Walking ☐ Worse in the a.m. ☐ Worse in the p.m.
Other: _____

What are your recovery goals? What do you want to achieve with PT? _____

_____

I have fully and accurately completed this form. I understand that providing inaccurate or incomplete information could negatively affect my recovery. It is my responsibility to update my physical therapist regarding my symptoms and functional limitations.

Patient/Guardian Signature: _____

# FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Sports Conditioning and Rehabilitation as your health care provider. We are committed to providing you with a successful physical therapy experience. The following is a statement of our Financial Policy and your agreement to follow our policy, which we require you to read and sign prior to your physical therapy evaluation or treatment. Our front office staff will give you an estimate of how much each visit will cost once we've received your insurance information. **Please protect yourself: We strongly encourage you to check with your insurance carrier(s) and to understand your policy with regards to physical therapy prior to your first appointment.**

*PRIVATE INSURANCE PLANS*: Please provide us with a copy of your current and valid insurance card and ID. All charges for services incurred by you, our patient, are your responsibility and will be expected to be paid in full. We are happy to verify your insurance benefits and submit claims to your insurance company as a courtesy to you. However, it is your responsibility to know your coverage limitations, and to pay your co-payments, co- insurance, and deductible.

Initial:_____

*DEDUCTIBLES AND CO-PAYMENTS* must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached. "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments." This is mandated by the federal government.

Initial:_____

*OUT-OF-NETWORK INSURANCE PLANS:* An out-of-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. Insurance plans do offer coverage for out-of-network providers. We are happy to verify your insurance benefits and to submit claims to your insurance company as a courtesy to you. However, it is your responsibility to know your coverage limitations ant to pay your co-payments, co-insurance, deductible. If payment from your insurance company is sent to you, it is your responsibility to either sign the checks over to SCAR, or to pay SCAR directly.

Initial:_____

*MEDICARE:* Medicare is the federal health insurance program for people who are age 65+, and younger people with specified disabilities or disease. We do accept Medicare patients; however, this does not mean that Medicare pays your bill in full. We are happy to verify your Medicare and any secondary insurance benefits and to submit your insurance claims as a courtesy to you. Medicare patients must pay their yearly deductible and are responsible for any portion that their secondary does not cover. Effective January 2020, Medicare allows $2,080.00 per year for physical therapy and speech therapy treatment combined. Any treatment beyond this threshold must be determined to be medically necessary by your physical therapist and is subject to Medicare review. Patients are responsible for any treatment costs not covered by Medicare and/or their secondary insurance coverage.

Initial:_____

*CASH/COLLECTION POLICY:* Our charges vary depending on the complexity of the diagnosis, the type and amount of procedures needed for your rehabilitation, the time required for your therapy sessions, and the amount of reimbursement from your insurance company. Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. For patients without insurance coverage, and those who have exhausted their physical therapy benefits, we offer a cash discount when paid at the time of service. We provide this option to make your healthcare accessible and affordable. If you choose to purchase medical equipment or supplies, please understand these items are **not returnable**, and payment is expected at the time of purchase.

| | |
|---|---|
| Initial evaluation: | $150 - $225 |
| Follow up treatment visits: | $85 - $170 |

*ACCOUNT BALANCES*: Please be advised that returned checks and balances older than 30 days from the dates of service might be subject to additional collection fees, along with interest charges of 1.6% per month. Initial:_____

We must emphasize that as a medical provider, our relationship is with you, not your insurance company.

I,_____, understand that **I am financially responsible for all insurance benefits that are deemed not medically necessary and/or eligibility that is not approved by my Health Insurance Plan**, pertaining to all charges related to services provided to me or my dependents.

_____ _____

Patient/Guardian Signature Date

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# SPORTS CONDITIONING AND REHABILITATION PAYMENT POLICY

Like most professional medical facilities, our physical therapy practice requires that all co-payments, co-insurance, and deductible payments are paid at the time of service. Our payment policy complies with the requirements of most insurance carriers that patients are responsible for paying their co-papyments, co-insurance, and/or deductible payments directly to the medical provider at the time of each visit. We will not ask for any unusual payments from you – only the amounts for which you are responsible. You may pay by cash, check, or credit card each visit.

You will be asked for a credit card at the time you check in for your first appointment, and your account information will be input, encrypted, and held securely in a cloud based server that is completely legally compliant. We will not store your personal credit card information in our office, and our staff will not have ongoing access to your account details.

When your portion of the bill is determined following a review of your copay, co-insurance, and deductible, we will charge your credit card account. You may request an email receipt or a printed copy.

If you do not have health insurance, payment in full is due at the time of service. We can assist you with applying for CareCredit, a healthcare credit account with beneficial financing options for those who qualify.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions or concerns, please do not hesitate to contact our billing company, Momentum Billing at (866) 875-6527 or info@momentumbilling.com.

We appreciate your understanding and cooperation.

Best regards,

Jim Herkimer, DPT, MS, ATC
President/CEO

*I agree to the above payment policy and take full responsibility for my co-payments, co-insurance payments, and all payments that are applied to my deductible.*

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

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# *APPOINTMENT CANCELLATION AND NO SHOW POLICY*

We strive to provide our patient with the utmost professionalism and service excellence. Our commitment to your well-being and progress toward your goals is something our entire staff takes very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of our own commitment to the care you need to receive, as well as our expectations of you.

Your commitment to your plan of care and participation in your treatment are essential for the best possible outcomes. This includes arriving for your appointments as scheduled – each time, on time. Your appointment is very important to us and to you; therefore, we apply the following rules to all patients:

With the exception of illnesses and emergencies, we expect you to keep all of your appointments with us. If you need to reschedule an appointment, we request at least 24-hours notice. If we do not receive 24-hours notice of your cancellation, it restricts our ability to accommodate other patients who might need that time slot. SCAR continually strives to provide the best possible care to all of our patients. Compliance with our cancellation and no show policy is necessary for both our staff and all patients who are arranging appointment times.

With a of cancellation without 24-hours notice, we reserve the right to charge you a $25 fee. If you do not show up for a scheduled appointment and fail to contact us within that same day, you will be charged a $50 no show fee. Repeated cancellations and/or no shows demonstrate a lack of commitment to your health and might result in your discharge from our care. We understand issues can come up that are beyond your control; therefore, late cancellation due to illness or family emergency is ***excluded*** from this policy.

_____ _____

Patient/Guardian Signature Date

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## APPOINTMENT PROCEDURES

Physical therapy sessions are by appointment only. Scheduling is based on a first come, first serve basis. It is best that you to schedule your appointments for your entire treatment plan, as prescribed by your physical therapist, to help ensure you receive your preferred days and times. It is your responsibility to schedule your appointments with our front office staff. Please do not ask your therapist to schedule your appointments. If you are unsure of your scheduled appointments, please check with our front office staff, and a reminder card will be provided to you. We also provide automated appointment reminders via phone, email, or text.

Please enter our clinic via our main entrance and check in with our front office staff for each appointment. You must check in prior to proceeding to the treatment area.

Please notify your physical therapist regarding the dates of your upcoming visits to your referring physician so that he/she may prepare a progress note and/or contact your doctor to provide an update regarding your care. If you already know when your next physician's appointment is scheduled, please indicate it below.

Next Physician Appointment Date: _____

If you have questions regarding any of the above policies or your treatment in general, please do not hesitate to ask our staff.

_____ _____

Patient/Guardian Signature: Date

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# SUMMARY OF NOTICE OF PRIVACY PRACTICES

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you were given the option to read/obtain our full Notice and that you received this summary.

YOUR RIGHTS AS A PATIENT. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

USE OF PROTECTED HEALTH INFORMATION. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

DISCLOSURES OF PROTECTED HEALTH INFORMATION NOT REQUIRING YOUR AUTHORIZATION. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

COMMUNICATION TO YOU OF CONFIDENTIAL INFORMATION BY ALTERNATIVE MEANS. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

RESTRICTIONS TO USE AND DISCLOSURE. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

ACCESS TO PROTECTED HEALTH INFORMATION. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

AMENDMENTS TO MEDICAL RECORDS. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

OTHER USES OF YOUR HEALTH INFORMATION. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

HOW TO LODGE COMPLAINTS RELATED TO PERCEIVED VIOLATIONS OF YOUR PRIVACY RIGHTS. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation. For a full copy please ask your physical therapist.

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# *ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY*

Use and disclosure of protected health information is regulated by the federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I, _____, acknowledge that Sports Conditioning and Rehabilitation of CA, Inc., has provided a written copy of its Notice of Privacy Practices for Protected Health Information to myself/guardian.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

When we need to contact you:

Which phone number may we call? (check all acceptable) Cell ☐ Home ☐ Work ☐

May we leave a message on an answering machine or with someone? Yes ◯ No ◯

May we contact you via email and text? Yes ◯ No ◯

Please provide the following contact information for medical providers with whom we may discuss your current or past condition:

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

Other (e.g., school Athletic Trainer): _____ Phone: _____

Please indicate anyone else with whom we may discuss your condition and/or care:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____

Patient/Guardian Signature Date

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