
Patient's Name _____ Date of Birth _____
Last First Middle

Social Security Number _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Employer/School _____ Occupation/Grade _____

If married, spouse's name _____ Social Security Number _____ Date of Birth _____

Spouse's Employer _____ Occupation _____ Business Phone _____

Email address: _____@_____._____ **(if minor, parent's email)**

Emergency Contact _____ Phone _____ Relation _____

**My next appointment with my doctor is:** _____ at _____AM/PM

**If Patient is a Minor, Please Complete the Following:**

**Father's Name** _____ Date of Birth _____

Social Security Number _____

Address (☐ Check Box if Same as Above) _____

City _____ State _____ Zip _____ Cell Phone _____

Employer _____ Business Phone _____

**Mother's Name** _____ Date of Birth _____

Social Security Number _____

Address (☐ Check Box if Same as Above) _____

City _____ State _____ Zip _____ Cell Phone _____

Employer _____ Business Phone _____

| ❖ PRIMARY INSURANCE | ❖ SECONDARY INSURANCE |
|---|---|
| INSURANCE CO _____ | INSURANCE CO _____ |
| POLICY # _____ | POLICY # _____ |
| GROUP ID # _____ | GROUP ID # _____ |
| NAME OF SUBSCRIBER _____ | NAME OF SUBSCRIBER _____ |
| DOB _____ | DOB _____ |
| RELATIONSHIP TO PATIENT: | RELATIONSHIP TO PATIENT: |

❖ **MOTOR VEHICLE / WORKERS COMPENSATION ACCIDENTS**

If your injury occurred in a motor vehicle accident or while on the job and you are filing your medical bills with an attorney or workers' compensation

INSURANCE CO./ATTORNEY _____
ADDRESS _____
_____
PHONE # _____

WORKERS COMP COMPANY _____
CONTACT NAME _____
PHONE # _____
CASE # _____

# FINANCIAL AGREEMENT

We have verified your insurance. As of today, the benefits are as follows:

Deductible: $_____/ $_____met Flat Copay per visit $_____
Insurance pays _____% Patient Co-insurance_____% Out of Pocket Max: $_____/ $_____met
Maximum dollar amount allowed per year for P.T. : $_____/ $_____used
Maximum visits allowed per year for P.T. : _____/_____used

We want to thank you for choosing AthletePlus as your healthcare provider. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services: Required at Check In:

1. Current picture ID and current insurance card along with payment for current visit & any outstanding balance.
2. If we are unable to confirm active coverage, you will be considered self pay and must pay for that visit.

**Payment Options:** Check, Echeck, Credit Card (Am Ex, Master Card, Visa), Apple Pay, PayPal, Care Credit. AutoPay/Recurring Payment Plans, Direct Self Pay/Membership Programs and Care Credit Financing available. If Self Pay or being treated as self pay because of high deductible, ask for our Self Pay Policy.

**Collections Policy** - Balances held over 90 days are subject to 1% interest charge or will be sent to Collection Agency with patient responsible for all fees.

_____ **Initial *PLEASE NOTE THIS IS ONLY A VERIFICATION OF BENEFITS, NOT A GUARANTEE AND IS SUBJECT TO CHANGE. ANY AMOUNTS NOT COVERED BY INSURANCE WILL BE YOUR RESPONSIBILITY.***

I understand I will be responsible for the amounts shown above. As a courtesy, we verify insurance benefits for patients. This in no way guarantees that your insurance company will pay exactly as quoted, benefits cannot be guaranteed over the phone. This facility is not responsible for obtaining or being aware of your policy requirement for referrals from your primary care physician, pre-certifications, or limits with your specific policy. Your insurance policy is a contract between you and your insurance company; therefore the responsibility lies with you, the patient, to be aware of this information. We will assist you if necessary to help you obtain this information. AthletePlus, is not obligated to withhold statements or to wait until settlement has been made before receiving payment for services. I understand that payment will be collected at the beginning each visit. AthletePlus does offer payment plans for your convenience; however we do reserve the right to refuse treatment if payment is not paid as per this agreement.

* For MVA and/or Patients with Attorneys who will not use their Health or Auto Insurance: We agree to bill third party liable parties (ex. MVA/Attorney cases) when we have all the claim information the patient has signed a medical lien. The patient, at the time of service will be responsible for a $25 lien fee filed at Washington County Courthouse and an initial payment of $75 for the evaluation. Should the third party be dismissed or limits exceeded, the patient will be billed at our self pay rates and be responsible for any collection fees. Also, we will only hold these charges for up to 20 months unless payment is received and we will not negotiate fees at the time of settlement.

By signing below, I state I have read this agreement in full and agree to it.

Responsible Party's Signature Date

Clinic Representative's Signature Date

**Date of injury/onset: ___/____/____** **Are you presently working/ playing a sport?** □ YES □ NO

**Have you ever had these symptoms before?** □ YES □ NO
**Check which apply to your symptoms:**

□ **Work related**
□ **Motor vehicle accident**
□ **Cause unknown**
□ **Injury recurrence of previous injury**
□ **Injury related to lifting**
□ **Athletic/Recreational injury**
□ **Injury related to falling**
□ **Other: _____**

**Are you presently working or playing a sport?** □ YES □ NO □ Light Duty Work

**Have you had a related surgery?** □ YES □ NO **If yes, Date of Surgery: ___/____/____**

**Describe your injury or symptoms:**

_____

_____

**CIRCLE the conditions below if you currently have, or you have had any of the following?**

**Diabetes**
**Chest Pain / Angina**
**High Blood Pressure**
**Heart Disease**
**Heart Attack**
**Heart Palpitation**
**Pacemaker**
**Headaches**
**Kidney Problems**
**Are you pregnant?**
**Cancer**
**Osteoporosis**
**Bowel/Bladder Abnormalities**
**Urine Leakage**
**Asthma/Breathing Difficulties**
**Liver/Gallbladder Problems**
**Smoking**
**Other**
**Allergy to Aspirin**
**Allergies to Heat**
**Allergies/Poor tolerance to Cold**
**Other Allergies**
**Hernia**
**Seizures**
**Metal Implants**
**Dizziness/ Fainting**
**Recent Fractures**
**Surgeries**
**Skin Abnormalities**
**Sexual Dysfunction**
**Nausea/Vomiting**
**Ringing in your ears**
**Rheumatoid Arthritis**
**Special Diet Guidelines**
**Hypoglycemia**
**Stroke**

**If you CIRCLED any of the above, please briefly explain and give approximate date:**

_____

_____

_____

**Is there any other information regarding your past medical history that we should know about?**

_____

**What are your goals for physical therapy or what activity will you be returning to upon graduation from AthletePlus?**

_____

**Are you presently taking any medication? □ YES □ NO If yes, please list below or give printed list.**

_____

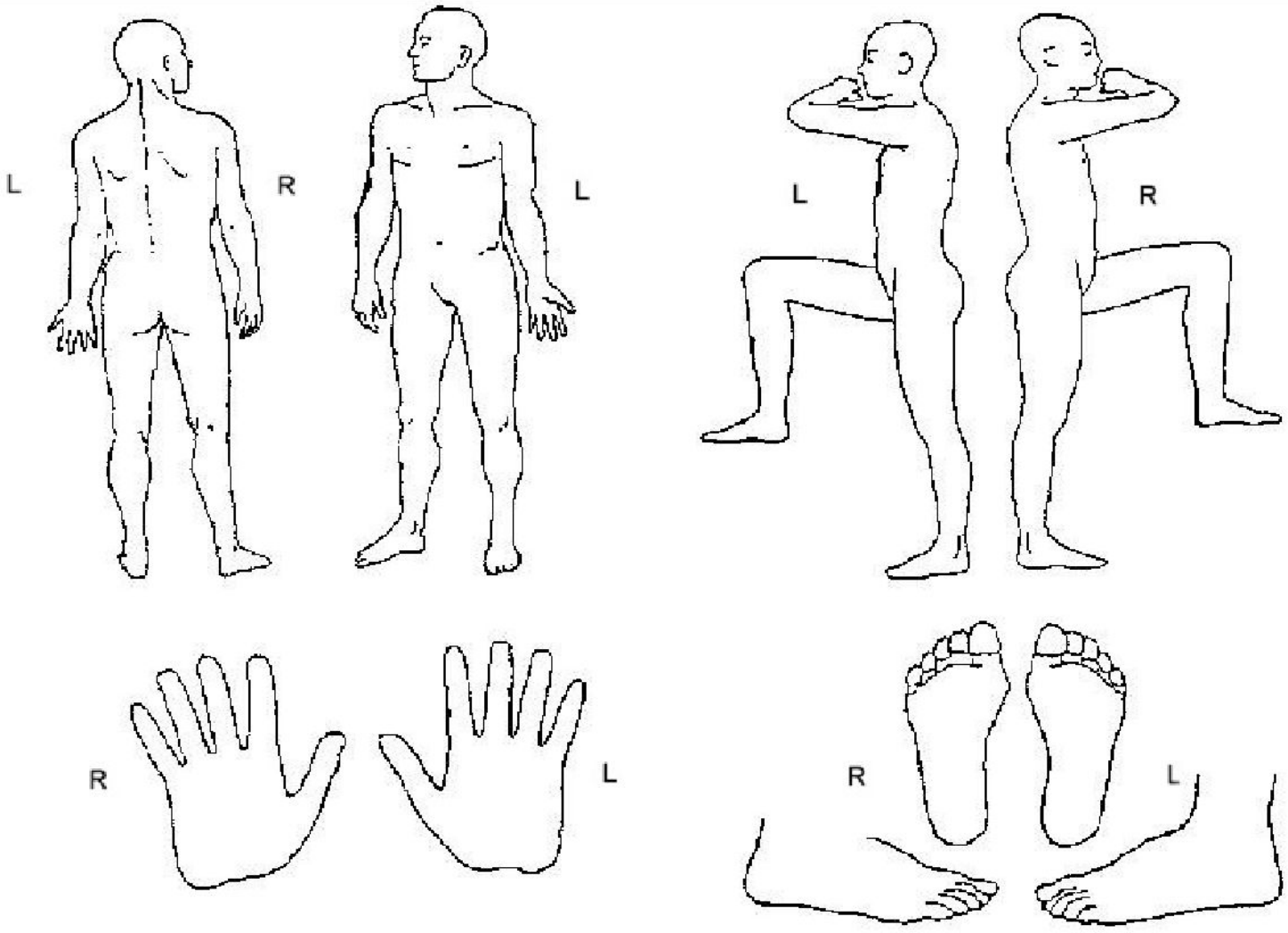
_____

**Does medication help decrease pain or symptoms?** □ Makes the pain go away completely □ Helps a little □ No help

# PAIN SCALE

**Using the symbols below, please mark the areas you are having discomfort:**

| Aching | Burning | Numbness |
|---|---|---|
| xxxxxx | /////////// | 000000000 |




**Please rate your pain using the following scale:**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | Mild Pain | Moderate Pain | | Distressed Pain | | Severe Pain | | Very Severe Pain | | Excruciating Pain |

# PATIENT RIGHTS ON PROTECTED HEALTHCARE INFORMATION
# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my Protected Health Information by AthletePlus for the purposes of diagnosis or providing treatment to me, obtaining payment or to conduct health care operations of AthletePlus. I understand that diagnosis or treatment of me by AthletePlus may be conditioned upon my consent as evidenced by my signature on this form.

1. I have the right to request a restriction on how my information may be used or disclosed to carry out treatment, payment, or health care operations of the practice.
2. I have the right to revoke this consent in writing at any time, except to the reliance AthletePlus may have upon my information.
3. My Protected Health Information includes my demographic information, collected from me and created or received by my physician, other health care provider, my insurance, employer or a health care clearinghouse. This Protected Health Information relates to my past, present, or future physical or mental health or condition.
4. I have been provided a copy of the AthletePlus HIPPA Policy.

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**PATIENT RIGHTS AND RESPONSIBILITIES**

## You have the right to:

1. Be treated with dignity, courtesy, and respect and expect AthletePlus to coordinate your care through regular communication with your physician, caregivers and other providers.
2. Receive competent, quality services regardless of age, race, color, national origin, religion, sex, disability, or any other category protected by law.
3. Have visitors attend therapy sessions at times if approved by therapist and visitation would not interfere with therapy session.
4. Refuse treatment to the extent permitted by law and to be informed of the consequences of this right.

## You have the responsibility to:

1. Provide complete and accurate information about your health and for reporting effects of physical therapy treatment.
2. Attend scheduled therapy sessions; participate in treatment activities and to be compliant with home exercise programs outlined by the treatment plan given to you.
3. Be considerate of the rights of other patients while participating in your rehabilitation program and notify the clinic as soon as possible concerning cancellation of scheduled appointment to allow adequate time to reschedule other patients.
4. Notify the clinic with at least 24 hour notice for cancellation of a scheduled appointment to allow time to reschedule other patients or be subject to a $25 cancellation fee per our No Show/Cancellation Policy.
5. Pay any balance not covered by your insurance, including co-pays, co-insurance, or deductibles. You will be billed and expected to pay the balance unless third party lien is signed as listed in the Financial Agreement. Collections Policy: Balances held over 90 days are subject to 1% interest charge or will be sent to Collection Agency with patient responsible for all fees.

_____ Initial *** I have read and understand the above Patient Rights and Responsibilities.**

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**MEDICAL RELEASE / CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS**

I request and authorize my insurance company(s) or Medicare to pay directly to AthletePlus, any proceeds payable under the terms of my policy(s). This is an irrevocable assignment; I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid by me. I grant AthletePlus consent to release my Protected Health Information to my insurance company(s) or my lawyer. I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital, and physical therapy pre-certifications, deductibles, co-insurance, and co-payment. I hereby authorize and consent to treatment rendered by AthletePlus as suggested by my physician or upon my own self-referral.

_____ _____

**SIGNATURE OF RESPONSIBLE PARTY** **PRINT NAME OF RESPONSIBLE PARTY**

_____ _____

**DATE** **RELATIONSHIP TO PATIENT**

7058 West Sunset, Suite 9A Springdale, AR 72762
Phone: 479-751-8437 Fax 479-802-0575
www.athleteplus.net therapy@athleteplus.net

618 W Center Greenwood, AR 72936
Phone: 479-996-2525 Fax 479-996-2526
greenwood@athleteplus.net