SSI
Sports Spine & Industrial
Physical Therapy and Performance Training Center

PATIENT INFORMATION

Date _____

Name ❒ Mr. ❒ Mrs. ❒ Miss _____ _____ _____
Last First Middle Initial

Patient Address _____

City _____ Zip Code _____

Home Phone _____Cell Phone _____ Work Phone _____ E-mail _____

Preferred Method of Contact _____

Employer _____

Sex ❒ Male ❒ Female Date of Birth _____ Social Sec. # _____ - _____ - _____

Marital Status _____ Spouse Name _____

Emergency Contact _____ Phone Number _____

RESPONSIBLE PARTY / INSURED INFORMATION (**Complete only if different from Patient**)

Name _____ Date of Birth _____

Address _____ Social Sec. # _____ - _____ - _____

_____ Zip Code _____

Home Phone _____ Employer _____ Work Phone _____

Responsible Party / Insured's Relationship to Patient ❒ Spouse ❒ Parent ❒ Child ❒ Other _____

Insured's Employer _____

Insured's Employer Address _____

INSURANCE INFORMATION

We will gladly file your medical insurance for you. Please note: you are responsible for any balance not paid by your insurance carrier. **In order for us to file you claims, we must make a copy of your insurance card.**

ACCIDENT / INJURY INFORMATION

Date of Injury / Accident _____ ❒ Auto ❒ Work ❒ Other _____

Description of Injury / Accident _____

How did you learn about SSI? (you may choose more than one)

__Advertisement __Website __Physician __Social Media __Chamber of Commerce __Other_____

__Past Patient/ Friend: _____ __ I'm a returning patient _____
Name When?

APPOINTMENT REMINDER CONSENT (Choose one of the following)

❒ I do not wish to receive appointment reminders ❒ I would like to receive appointment reminders by phone
❒ I would like to receive appointment reminders by email

SIGNATURE OF PATIENT _____

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BRIEF MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Patient Name:		Height:	Weight:
Reason for Therapy:		Date of injury or onset:	

Have you ever received therapy for the condition mentioned above? ❒ No ❒ Yes	If so, when?
Have you ever received therapy at SSI? ❒ No ❒ Yes	If so, when?

Are you currently receiving ANY TYPE of Home Health Care? ❒ Yes ❒ No

Do you now or have you EVER had any of the following? **CHECK ONLY THE ONES THAT APPLY.**

Condition	Yes	Condition	Yes
Cancer. If YES, what type:		Thyroid Problems	
Diabetes		Gastrointestinal problems (i.e. hernia, ulcers)	
Heart Problems (i.e. heart attack, heart disease, stent)		Kidney disease/ urinary tract infection/ kidney stones	
Pacemaker		Urinary Incontinence	
High Blood Pressure		Circulation Problems (i.e. Blood clot, peripheral vascular disease, varicose veins, Reynauds)	
CVA/Stroke/ TIA		HIV/Hepatitis	
Parkinsons		Dizziness/ ringing in ears/ vertigo	
Epilepsy/Seizures/Tremors		Vision problems	
Multiple Sclerosis		Open wound or infection (skin, bone, joint)	
Lupus/ Fibromyalgia		Depression/ Anxiety	
Arthritis or rheumatoid disease		Edema/Swelling/lymphedema	
Asthma/ Emphysema/ COPD		Nicotine use	
Tuberculosis		Allergies. If YES, circle type: latex/ adhesive tape/ bee sting/ aspirin/steroids/anti-inflammatories /other:	
Osteoporosis/ osteopenia		Are you currently pregnant or think you might be pregnant?	
Fractures. If YES, describe where:			

Have you RECENTLY (last 2-3 weeks) noted any of the following: (check all that apply)

❒ Significant weight loss/gain ❒ Nausea/Vomiting ❒ Fatigue ❒ Headaches
❒ Dizziness/Light-headedness ❒ Fever/Chills/Sweats ❒ Numbness or tingling ❒ Weakness

If you checked **any of the above**, please explain and give approximate dates: _____

_____

_____

Please list any **surgeries or other conditions (and approximate dates)** for which you have been hospitalized (including orthopedic surgeries, joint replacements, C-section, abdominal surgeries, etc.):

1._____ 2._____

3._____ 4._____

5._____ 6._____

Please list any medications (prescriptions, over the counter, vitamins) you are currently taking, *including dosage and frequency*:

Medication Name	Dosage	Frequency

The information above is correct to the best of my knowledge.

Patient/Parent/Guardian Signature	Date
Reviewed and Verified by PT	Date

PATIENT NAME: _____

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CONSENT TO TREATMENT / RELEASE OF INFORMATION

I hereby consent to treatment. I authorize payment directly to SSI, its subsidiaries and/or affiliates for services. This is a direct assignment of my rights and benefits under this policy. I authorize SSI, Inc. and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I have received SSI's Notice of Information Practices. I understand that SSI and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that SSI will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

PAYMENT GUARANTEE

1. SELF-PAY / NO INSURANCE – If you have no insurance coverage, the charges incurred will be your responsibility. Payment is expected at each visit.

2. GROUP INSURANCE – After verification of coverage with your insurance company/companies, we will file a claim as a courtesy to you. SSI will file up to two insurance companies. Any remaining charge will be the responsibility of the patient. If your deductible is not met or cannot be verified, WE WILL REQUIRE YOU TO PAY YOUR DEDUCTIBLE AMOUNT. We then require that you pay the percentage/co-pay due by you at each visit.

3. WORKER'S COMPENSATION – We will verify your worker's compensation coverage with your employer or the company where you were employed at the time of your accident. After verification, we will file your claims for you. If your worker's compensation is denied for any reason, YOU will be responsible for your bill. If we have to file your group insurance (because your worker's compensation was denied), any amount not paid by your group insurance will be YOUR responsibility. Missed appointments will be reported to your employer, case manager and physician and documented in your clinical record. Missed appointments may lead to the disruption of your worker's compensation payments if you do not follow the directives of your physician for treatment.

I understand that if I do not pay my balance or set up a payment plan, I may be turned over to collections which will incur an additional 25% collection fee.

CANCELLATION/ NO SHOW POLICY

In order to receive maximum benefit from your therapy, it is important to keep your scheduled appointments. If you are unable to attend a physical therapy session, please notify our office 24 hours in advance. You can leave a message after hours on our answering service. **If you do not give 24 hour advanced notice of a cancellation, or simply do not show for an appointment, you will be responsible for a $30 cancellation/no show charge, which will be due prior to your next treatment.** Please notify your therapist if there are extenuating circumstances that made attendance impossible. If you cancel or fail to show for 3 consecutive appointments, you may be discharged from therapy. Appointments will be rescheduled only after discussion with your therapist and payment of any outstanding cancellation/no show fees.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SPORTS SPINE & INDUSTRIAL'S LEGAL DUTY

Sports Spine & Industrial, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Sports Spine & Industrial, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Sports Spine & Industrial, Inc***. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Sports Spine & Industrial, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ***Sports Spine & Industrial*'s** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Sports Spine & Industrial, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***Sports Spine & Industrial, Inc.*** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Sports Spine & Industrial, Inc.*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***Sports Spine & Industrial'*s** health information practices or if you have a complaint, please contact the following person:

Sports Spine & Industrial, Inc.
Security/Privacy Officer
PMB 207, 1361-F W. Wade Hampton Blvd, Greer, SC 29650
Telephone: (864) 801-8706 Fax: (864) 848-7203