Self-Pay / Maintenance Therapy Agreement

Patient: ______________________________ **Date:** ______________

_____ I do not have insurance or I have exhausted the benefits under my Insurance plan.

_____ I do not have a physician referral or order for Physical Therapy.

_____ I do not wish to submit claims to my insurance company.

_____ I have not met my insurance deductible of $______________ and /or would like to arrange a budgeted payment plan: $______________ per visit / week / other: _______

_____ My insurance does not cover treatment or services that are not medically necessary or skilled therapy is no longer required (Maintenance) and continued therapy will not be covered by insurance.

_____ My insurance benefits are currently suspended pending authorization or the outcome of a hearing or appeal.

_____ I am pursuing legal proceedings to cover my medical expenses.

_____ I am not a U.S. citizen and I plan to submit to my insurance company on my own.

_____Provider/Facility is not in Network with my Insurance: ______________________

I UNDERSTAND AND AGREE TO:

The Self Pay / Maintenance Therapy Rate of **$: _$100.00_ Eval & _$85.00_ per visit.**

Therapy & Sports Center requires payment at the time of service. It is not our policy to "wait for settlement" or for the outcome of a hearing or insurance appeal. I understand and agree to the terms of the above said agreement and wish to receive the services for therapy.

Patient Signature: ________________________________ **Date**: ____________

Office Staff Signature: ______________________________ **Date**: ____________

412 12th Avenue North, Saint Petersburg, FL, 33701, 727-898-5001 phone / 727-894-0554 fax
1236 Druid Road East, Clearwater, FL, 33756, 727-442-2236 phone / 727-442-2646 fax
305 West Roberson, Brandon, FL 33511, 813-651-3900 phone / 813-651-3911 fax
13011 Summerfield Square Drive, Riverview FL 33578, 813-374-2209 phone / 813-374-2211 fax

THERAPY AND SPORTS CENTER

NEW PATIENT PAPERWORK

NAME: Last: ______________________ **First:** ______________________ **M / F**

DATE OF BIRTH: ____/____/____ **SOCIAL SECURITY #:** ______________________

PHONE: Home: ______________ **Work:** ______________ **Cell:** ______________

ADDRESS: ____

CITY: ______________________ **STATE:** __________ **ZIP CODE:** __________

E-MAIL ADDRESS: ____

Emergency Contact: ______________ **Relationship:** __________ **Phone #:** ______________

Next Appointment date with Referring Physician: ______________________

INSURANCE: SELF PAY - SEE MAINTENANCE AGREEMENT

****IS YOUR INJURY / DIAGNOSIS RELATED TO ANY OF THE FOLLOWING:*** **(If YES, Please √ below)**

☐ ***AUTOMOBILE ACCIDENT*** ☐ ***WORK RELATED (on the job injury)*** ☐ ***SLIP & FALL LAWSUIT***

Is there an attorney involved? YES / NO ***If yes, please provide name and phone # below:**

Attorney Name/Firm: ______________________ **Phone #:** ______________

***NOTE - ALL PAYMENTS ARE DUE AT THE TIME THE SERVICES ARE RENDERED.**

______________________ ______________
Patient Signature **Date**

THERAPY & SPORTS CENTER – Patient Medical History Form

Name: ______________________ D.O.B: ____________ Date: __________

Referring Dr: __________ /#: __________ Primary Care Dr: __________ /#: __________

SOCIAL HISTORY: What is your occupation: __________ □ Full Time □ Part Time □ Unemployed □ Self Employed □ Retired □ Homemaker □ Student □ Other: __________

Do you live alone?: Yes / No *List any physical barriers in your residence that cause you difficulties: __________

IS YOUR CONDITION RELATED TO AN AUTOMOBILE, WORK RELATED OR SLIP & FALL INJURY?: □YES □NO

If yes, when was the date of injury: __________ In what State did the injury occur?: __________

Claim Adjuster's Name: __________ Phone#: __________ Fax#: __________

Do you have an attorney?: □ Yes □ No Attorney Name/Firm: __________ Phone #: __________

Have you had surgery for this injury? YES / NO Date of surgery: ___/___/___ Type of surgery: __________

MEDICAL HISTORY: Height: ______ Weight: ______ Do you/have you ever Smoked?: □Yes □ No

How would you rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any allergies: __________

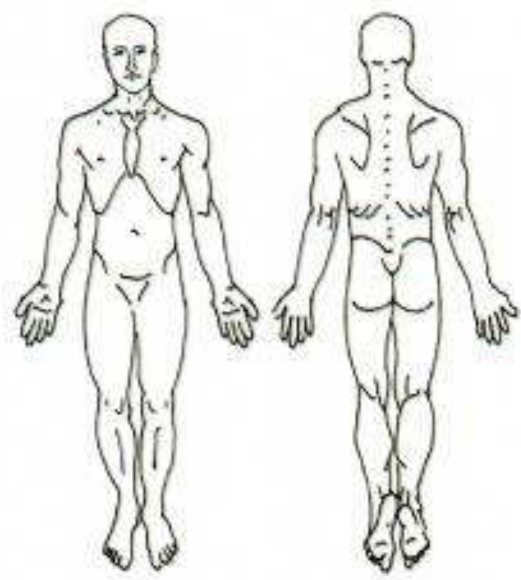
Please list current Medications: __________

Do you now have or have you ever had ANY of the following?

	YES	NO
Asthma, bronchitis or emphysema	____	____
Shortness of breath/chest/pain	____	____
Coronary heart disease/angina	____	____
Heart attack or heart surgery	____	____
Do you have a pacemaker?	____	____
High blood pressure	____	____
Stroke/TIA Date: ___/___/___	____	____
Blood clot/emboli	____	____
Epilepsy/seizures	____	____
Anemia	____	____
Infectious diseases	____	____
Diabetes	____	____
Cancer or chemotherapy	____	____
Arthritis/swollen joints	____	____
Osteoporosis	____	____
Severe/frequent headaches	____	____
Vision/hearing difficulties	____	____
Dizziness/fainting	____	____
Weight loss/energy loss	____	____
Hernia	____	____
Sleeping prob/difficulties	____	____
Any joint/metal implants	____	____
Joint replacements	____	____
Shoulder injury/surgery	____	____
Elbow/hand injury/surgery	____	____
Neck/back injury/surgery	____	____
Knee injury/surgery	____	____
Leg/ankle injury/surgery	____	____
Are you pregnant?	____	____

On the body diagram below SHADE IN THE AREA(s) you are having pain, tingling or numbness with this episode

INDICATE: X for pain, = for numbness, * for tingling, # for burning



On a scale of 0 (no pain) to 10 (severe/disabling pain), rate your pain at at its BEST: __________ / WORST: __________

On a scale of 0% (worst) to 100% (best) what percentage of normal function are you able to perform? (This includes work performance, home activity, sports, socially with friends: __________

CURRENT EPISODE: When did your symptoms this episode start: Date: __________ Describe your symptoms: __________

How often do you experience your symptoms?: Constantly: ______ Frequently: ______ Occasionally: ______ Rarely: ______

How much have your symptoms interfered with your daily activities?:
Never: ______ A little bit: ______ Moderately: ______ Quite a bit: ______ Extremely: ______

Have you had similar symptoms in the past?: Yes: ______ / No: ______

Who did you see for your symptoms: No One: ____ Medical Doctor: ____ Chiropractor: ____ Physical Therapist: ____ Other: ______

What treatment(s) did you receive?: X-Rays: ____ MRI: ____ CT Scan: ____ Surgery: ____ Other: ______

Patient Signature: ______________________ **Date:** __________

COMMERICAL, W/C, AUTO, MEDICARE REPLACEMENT PLANS

CONSENT FOR TREATMENT

I hereby give my consent for treatment rendered by Therapy and Sports Center, Inc., to myself/dependent as prescribed by my physician. I realize that in order to provide the best possible care, T&SC may need to contact my doctors. In giving my consent to be treated, I am also giving my consent for T&SC to contact my doctors.

PATIENT'S SIGNATURE: ______________________________ **DATE:** ______________

PARENT/GUARDIAN: ______________________________ **DATE:** ______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT ON MEDICAL BENEFITS

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition, including the history obtained, physical findings, diagnosis, and prognosis to my designated insurance carrier. In addition, I authorize payment of medical benefits to be directly made to T&SC.

SIGNATURE: XXXXXXXXXXXXX **SELF PAY** XXXXXXXXXXXXX **DATE:** XXXXXXXXXXXXX

GUARANTEE OF PAYMENT

I understand that Therapy And Sports Center, Inc., will file my insurance claims for me with an assignment of benefits. I am responsible for any balance not paid to you by my insurance company within a reasonable length of time. Co-pays are due at time of service. I also agree that in the event that T&SC is required to bring any legal action against me to collect payment for treatment, I will be responsible to pay attorney's fees and court costs which may be required.

SIGNATURE: XXXXXXXXXXXXX **SELF PAY** XXXXXXXXXXXXX **DATE:** XXXXXXXXXXXXX

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by T&SC for the purpose of providing treatment to me, obtaining payment of my healthcare bills or to conduct health operations of T&SC. I undersand that the treatment of me by T&SC's professional staff may be conditional upon my consent as evidenced by signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. T&SC is not required to agree to the restrictions that I may request, however, if T&SC agrees to a restriction that I request, the restriction is binding on T&SC and their staff. I have the right to revoke this consent, in writing, at any time, except to the extent that the professional staff of T&SC has taken action in reliance on this consent. My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician,another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to review T&SC's notice of privacy practices prior to signing this document. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of T& SC. The notice of privacy practices for T&SC is made available at office. This notice also describes my right and T&SC's duties with respect to my personal information. T&SC reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a revised notice of privacy practices by calling the office and requesting one be sent to me in the mail.

SIGNATURE: ______________________________ **DATE:** ______________

Who else may Therapy And Sports Center, Inc., discuss your medical or billing information with?

____

These signatures **witnessed** by office staff: ____________________ **DATE:** ______________