SCORE Performance Medicine Intake Form

Commercial Insurance

Date:_____

Name: _____ DOB: _____ Circle: Male/Female

Address: _____ City _____ State _____ Zip _____

Cell Phone: _____ SSN: _____ Date of Injury: _____

Emergency Contact Information: _____

Primary Care Doctor: _____ Referring Physician: _____

Primary Health Insurance Company _____

ID # _____ Group # _____

Is your insurance in your name: Yes / No

Subscriber Name _____ Subscriber SSN _____

Subscriber Address _____ City _____ State _____ Zip _____

Subscriber Phone Number _____ Subscriber Gender: Male / Female

Subscriber DOB _____ Subscriber Relation to Patient _____

Subscriber Employer _____

Subscriber Employer Address _____ City _____ State _____ Zip _____

Please present your insurance card(s) for photocopy

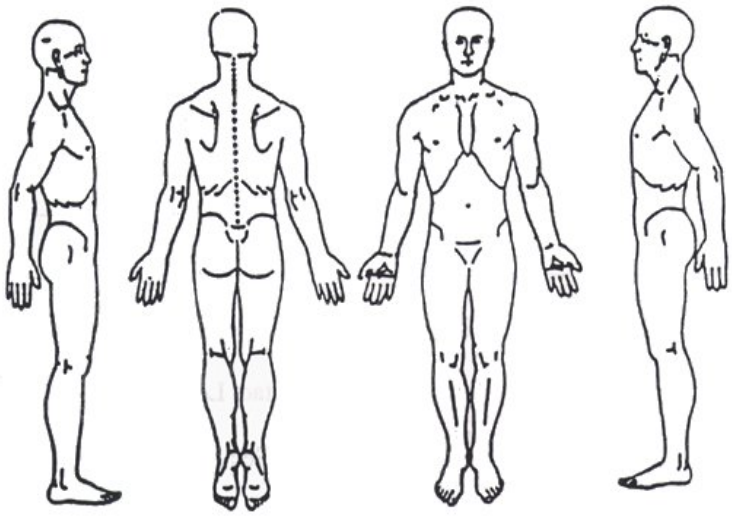
When and how were you injured?

What were the date of and results of any medical imaging and testing that you have had?

X Ray: _____ CT Scan:_____

MRI: _____ Other: _____

Please shade on this diagram where your pain and/or abnormal sensations are felt.



Please describe your pain in your own words (ie. dull, achy, sharp, throbbing, deep):

Please rate your pain over the last 2 weeks on this scale by circling the <u>lowest</u> (1), <u>current</u> (2), and <u>highest</u> (3) level of pain.

0 -1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 -10

Low range moderate pain range severe pain range

Medical History:

Please check any current medical conditions that you may have

Heart Attack/MI		**Vascular Disease**	
Cardiac Arrhythmia/Pacemaker		**Open Wounds**	
High Blood Pressure		**Osteoporosis**	
Coronary Artery Disease		**Osteoarthritis**	
Diabetes		**Rheumatoid Arthritis**	
Stroke CVA/TIA		**Lupus/SLE**	
Cancer		**Multiple Sclerosis**	
Epilepsy/Seizures		**Parkinson's Disease**	
Infectious Disease		**Migraines**	
Currently Pregnant		**Fracture**	
Vertigo		**Location of Fracture(s):**	

<u>Please list</u>

1) **Any other medical conditions that you have:**

2) **Past surgical history with the year surgery was performed:**

3) **Medications and supplements that you are taking:**

Have you experienced any of the following in the past month? (please check):

Recent bowl or bladder changes		**Cancer History**	
Abdominal Masses		**Night sweats, Fever**	
Unexplained tingling, numbness, weakness		**Blood in Sputum/Coughing up blood**	
Unexplained weight loss		**Pain that is not able to be relieved**	

Financial Policy
Appointment and Cancellation Policies

We are committed to providing you with the best possible care. We will gladly discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Payment is due for services at the time services are rendered. This includes coinsurance, copayment, and deductible payments. If a check is returned for insufficient funds, you will be charged a bank fee in addition to the amount of the check.

After the insurance company has paid their portion of your claim, you are responsible for any unpaid charges on your bill. You will have 90 days to pay your bill before it is turned over to a collection agency. You will be responsible for any fees the collection agency charges.

I understand that my doctor has prescribed physical therapy, or I have chosen physical therapy without a doctor's referral. I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress.

I give my permission for SCORE Performance Medicine to provide information as needed to my insurance company.

Appointments: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival greater than 15 minutes may result in a shortened treatment or cancellation.

We require 24-hour notice of cancellation or a $25 fee may be assessed. You are directly responsible for this payment. Three episodes of absence from a physical therapy session without cancellation will result in discharge.

_____

Signature of patient or guardian (if minor) indicates acknowledgement and agreement of above

Patient Authorization for Use and Disclosure of Protected Health Information
Statement of Privacy Notice

We may disclose your health care information:

1. To other health care professionals within our practice for the purpose of treatment, payment, or health care operations
2. To your insurance provider for the purpose of payment or healthcare operations
3. To comply with State Worker's Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures
5. In the course of any administrative of judicial proceeding or law enforcement purposes

Under the HIPPA federal privacy law you have the right to:

1. Request restrictions on certain uses and disclosures of your health information
2. Inspect and copy your health care information
3. Receive an accounting or disclosure of your protected health information
4. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your health information.

If you have any questions regarding this notice of if you want more information about your privacy rights, please contact us at 716-302-3294.

My signature indicates my authorization and consent for SCORE Performance Medicine to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described above.

_____

Patient's Name (print)

_____

Patient's Signature