



Registration Form

Date: \_\_\_\_\_

Patient Information

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Widowed  Divorced

Email Address \_\_\_\_\_

Spouse or Parent's Name: \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Phone \_\_\_\_\_

Responsible Party / Insurance Information

Primary Insurance: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_

Workers Comp Information

Is this a work related injury? Yes  No  Date of Injury \_\_\_\_\_

Employer \_\_\_\_\_ Workers Comp Carrier \_\_\_\_\_

Employer address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact/phone \_\_\_\_\_ Contact/phone \_\_\_\_\_

The above information is true to the best of my knowledge,

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical Screening Form

Please circle one:

<u>Have you or any immediate family member ever been told you have:</u>					
	Self		Family		
	Yes ...	No	Yes ...	No	
Cancer	Yes ...	No	Yes ...	No	Angina / Chest Pain
Diabetes	Yes ...	No	Yes ...	No	Stroke
High blood pressure	Yes ...	No	Yes ...	No	Osteoporosis
Heart disease	Yes ...	No	Yes ...	No	Osteoarthritis
Pacemaker	Yes ...	No	Yes ...	No	Rheumatoid arthritis
					Yes ... No

<u>In the past 3 months have you had or do you experience:</u>			
A change in your health	Yes ...	No	Difficulty swallowing
Nausea / vomiting	Yes ...	No	Numbness or tingling
Fever / chills / sweats	Yes ...	No	Shortness of breath
Unexplained weight change	Yes ...	No	Upper respiratory infection
Dizziness	Yes ...	No	Changes in bowel or bladder function
Changes in appetite	Yes ...	No	Urinary tract infection
			Yes ... No

<u>Do you have a history of:</u>					
Allergies / Asthma	Yes ...	No	Rheumatic Fever	Yes ...	No
Headaches	Yes ...	No	Ulcers	Yes ...	No
Seizures	Yes ...	No	Bronchitis	Yes ...	No
			Kidney Disease	Yes ...	No

Are you currently...

Depressed Yes ... No

Under stress Yes ... No

Are you able to sleep at night?

Yes ... With some problem ... No, only with medication

Do you or have you in the past smoked tobacco?

Yes ... No If yes, \_\_\_ packs x \_\_\_ years.

Last tobacco use \_\_\_\_\_.

Date of last physical examination: \_\_\_\_\_

Medications currently using: \_\_\_\_\_

\_\_\_\_\_

Exercise / Activity level: \_\_\_\_\_

Type of activities? \_\_\_\_\_

Are your symptoms...

Getting worse ... The same ... Improving

Do you have a problem with... (check all that apply)

\_\_\_ Vision \_\_\_ Speech

\_\_\_ Hearing \_\_\_ Communication

Do you drink alcoholic beverages?

Yes ... No If Yes, how many drinks do you routinely have per week? \_\_\_ x week

Prior surgeries \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

Type of work: lifting/ prolonged standing, etc

\_\_\_\_\_

Please rate your current level of pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your worst level of pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale:

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)



## Statement of Financial Policy

Swing Orthopedic Sports Physical Therapy appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Please contact your insurance company to verify coverage of our services. We allow 60 days for your insurance company to pay. After that time the unpaid balance is due to payable by the patient.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect the co-payments to be paid at time of service. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

### Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancel your appointment. No show may result in a \$15.00 fee, which will not be paid by your insurance company.

### Returned checks and overdue accounts

There is a \$10.00 service fee on all returned checks. Accounts passed due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.

### Self-Pay

If you do not have insurance coverage or if you prefer to file your own insurance, you are expected to pay all charges in full at time of service.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

-----  
PATIENT NAME

-----  
SIGNATURE

-----  
DATE

### Consent for Treatment and Authorization to Release Information

I hereby authorize Swing Orthopedic Sports Physical Therapy, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Swing Orthopedic Sports Physical Therapy, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I authorize payment directly to Swing Orthopedic Sports Physical Therapy for services I receive.

Initials:



15455 W Bell Road  
Surprise, AZ 85374

### *Notice of privacy practices acknowledgement*

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance companies and third-party payers.
- Conduct normal healthcare operations such as physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Swing Orthopedic Sports Physical Therapy, Inc. at any time at the above address to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Print name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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#### **OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date \_\_\_\_\_ Initials \_\_\_\_\_

Reason \_\_\_\_\_