Date: _____ **SPORTS REHAB AND PROFESSIONAL THERAPY ASSOCIATES, INC.** Therapist: _____

Have you been a patient here before? Yes No

Patient (last, first, MI): _____ Social Security #: _____

Address (street or PO Box): _____ Date of Birth: _____ Gender: M F

City: _____ State: _____ Zip: _____ Marital Status: S M D W Home Phone: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

E-Mail (for appt. reminders):_____ OK to leave a voice mail message: Yes No

Emergency Contact: (name, relationship, daytime phone#) _____

Referring Doctor: _____ Referral Date: _____ E-mail address: _____

Chief Complaint: (please circle) neck back shoulder arm wrist hand hip leg knee ankle foot other _____

Was this due to a specific accident or injury: Yes No Date of Injury: _____ If yes, please state nature of injury: _____

Is this a work related injury? Yes No If yes, please list contact person at your employer: _____

If this is an MVA, please state date and location of MVA: _____

If this is a personal injury/liability case, do you have an attorney? Yes No Atty. Name: _____

Have you had physical, occupational or speech therapy previously this calendar year? Yes No

Are you receiving HOME HEALTH care of any type? Yes No

FINANCIAL INFORMATION ---

Responsible Party (full name): _____ Social Security #: _____

Address (street or PO Box): _____ Date of Birth: _____ Gender: M F

Relationship to Patient: self parent legal guardian

City: _____ State: _____ Zip: _____ power of attorney spouse

PRIMARY INSURANCE INFORMATION---(Copy of Card required to submit to insurance) if unable to provide copy, please list insurance ID #'s & phone #'s on back

Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: self parent legal guardian

Date of Birth: _____ Gender: M F power of attorney spouse

SECONDARY INSURANCE INFORMATION---(Copy of Card required to submit to insurance) if unable to provide copy, please list insurance ID #'s & phone #'s on back

Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: self parent legal guardian

Date of Birth: _____ Gender: M F power of attorney spouse

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES I have been offered/received a copy of the Notice of the Privacy Practices of Sports Rehab & Professional Associates. Patient (or Parent/Guardian Signature) _____

I would like to designate the following person to have access to my health information: _____

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS -- I give my consent for physical/occupational/speech therapy treatments to be performed by Sports Rehab & Professional Therapy Assoc., Inc. Treatments will be administered under the direction of my physician (if applicable) and a therapist licensed by the State of Iowa. I understand that no guarantees have been made as to the outcome of this treatment. Sports Rehab may release any of my therapy records to my physician, the insurance company/companies listed, my employer (in a work comp situation) or my attorney (if listed). Any other requests for release of information must be directed to Sports Rehab in writing. I authorize all insurance benefits/payments to be paid directly to Sports Rehab.

Note – The patient (or parent/guardian) is responsible for checking with insurance to determine their coverage for therapy services.

BILLING AND PAYMENT POLICY – I understand that I am responsible for this account. Sports Rehab does charge a 1.5% service charge per month on all balances over 120 days. Accounts over 120 days past due will be reviewed for further collection proceedings. Statements are sent out monthly. ***If this is a workman's compensation account,*** you will not receive a monthly statement. However, if the worker's compensation insurance denies responsibility, the patient is liable for all charges. ***If your treatment is related to an injury or accident which involves legal proceedings,*** payment arrangements must be made with the billing office at the start of your treatment. My signature below indicates that I have read and understand this consent, authorization and the billing/payment policy.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witnessed By: _____ Date: _____