Patient Information		
Patient Name:		Date of Birth:
Address:		
City:	State:	Zip:
Cell Phone Number: Can you receive text messages? Y / N	Home Phone Number: Preferred Contact Method:	
Email Address (will also be used for appointment reminders):		
Gender: Male / Female	Marital Status: Single / Married / Other	
Social Security Number:		
Driver's License Number:		
Emergency Contact Name:	Relationship:	Phone:

Employer Information			
Employer Name:		Phone:	
Employer Address:	City:	State:	Zip:
Spouse's Employer Name:			
Spouse's Employer Address:	City:	State:	Zip:

Primary Insurance Information (please provide insurance card - or list ID#'s and phone # of insurance)		
Insurance Company:		
Insured Name:	Date of Birth:	Gender: M / F
Relationship to Patient:		

Secondary Insurance Information (please provide insurance card - or list ID#'s and phone # of insurance)		
Insurance Company:		
Insured Name:	Date of Birth:	Gender: M / F
Relationship to Patient:		

Responsible Party			
Name:		Relationship:	
Address:	City:	State:	Zip:

Continued on back

Referral Information

Referring Physician (address & phone if known):

Chief Complaint or Injured Area:

Date of Injury: Not due to an accident _____ Auto _____ Work _____ Other _____

If other - please explain:

Have you had therapy this calendar year? # of visits: ___________

If Auto, list state where accident occurred and provide Insurance Carrier information:

If Work Related, list employer contact / adjustor name & phone number

If an Attorney is involved, please list attorney name and contact information:

Required Medicare Secondary Payer Questions

Per the injury information completed above - Is there another insurance that is responsible primary to Medicare? ☐ Yes ☐ No

Are you covered through an employer group plan or a spouse's employer group plan? ☐ Yes ☐ No

Are you receiving Black Lung (BL) benefits? ☐ Yes ☐ No

Are you receiving any Home Health care? ☐ Yes ☐ No

Patient Consent and Signature

Notice of Privacy Practices (HIPAA Acknowledgement/Consent) I have been offered/received a copy of the Notice of the Privacy Practices of Sports Rehab & Professional Therapy Associates, INC. I give my permission for the following person to have access to my medical information. ______________________________ ➡ **INITIAL: ____________ Date: __________**

Consent to Treat / Authorization to Release Information / Assignment of Benefits I give my consent for therapy treatments to be performed by Sports Rehab & Professional Therapy Associates, 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 regarding 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 request 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.

Billing & Payment Policy I understand that I am responsible for this account and that I am further responsible for checking with my insurance to determine their coverage for therapy services. Sports Rehab does not guarantee insurance benefit information. All copays should be made at time of service. Accounts over 120 days will accrue service charges if regular payments are not received. Payment plans can be arranged with the business office. Past due accounts will be considered for collection proceedings.

I certify that the information I have provided is correct. I have read, understand and agree to the above stated policies.

➡**Patient Signature: ____ Date: _____________**

Parent or Guardian Signature: ____________________________________ Date: ____________

Witnessed by: ____ Date: ____________

Sports Rehab & Professional Therapy Associates, Inc. does not discriminate on the basis of race, color, national origin, disabiilty or age.