SPORTS CENTER
PHYSICAL THERAPY

Welcome to Sports Center! Please fill out the following information.

Contact Information

_________________________________ _________________________ _____
Last Name First Name MI

___________________________ ______________________________________
Date of Birth Social Security Number (required for insurance)

____
Street Address

_____________________________ _________ _____________________
City State ZIP code

___________________ ___________________ ____________________
Home Number Work Number Mobile Number

____
E-mail Address

___________________________________ ____________________________
Emergency Contact Name Emergency Contact Number

Primary Care Physician: ____

****

If your insurance policy is listed under someone other than the person above, please provide their name and contact information below:

Name: __________________________________ Relationship:_____________________

Address: _____________________________________ DOB: _____/_____/_________

City:________________________ State:_____________Zip:______________________

Contact Phone Number: (____) ____

1600 West 38th Street, Suite 201 Austin, TX 78731
P: (512) 206-0433 F: (512) 206-0797 www.sportscenteraustin.com

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Clinical Information

Name ______________________ Age ________ Today's Date ____/____/____

Occupation: ______________________ Employer: ______________________

Email: ______________________ Phone:(_____)______________________

How did you hear about us? My Physician Our website Friend Other: ______________________

What are your goals? What do you want to get back to? ______________________

Status Score

Circle the number under each category that best describes your situation.

Pain

0	1	2	3	4	5	6	7	8	9	10

No Pain — Intermittent — Severe, Constant

Medication Use

0	1	2	3	4	5	6	7	8	9	10

No medication use — Daily non-narcotic — Daily Narcotic

Activity Restriction

0	1	2	3	4	5	6	7	8	9	10

Housebound — Restrictions in daily life — No restrictions

Overall Condition

0	1	2	3	4	5	6	7	8	9	10

Poor / Very dissatisfied — Average / Moderately satisfied — Excellent / Very Satisfied

Office Use

10 - ___ = ___

10 - ___ = ___

____

____

Calculation

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Consent for Treatment

I authorize my assigned physical therapist and whomever he/she may designate as his/her assistant to administer treatment as is necessary.

I give permission for my physical therapist and their support staff to treat me in an open room where others are also being treated. I am aware that other persons in the clinic may overhear some of my protected health information during the course of care. Should I need to speak to my physical therapist or their support staff at any time in private, a private room for these conversations will be provided to me.

I understand that I will be responsible for handling my physical therapy treatment chart, which we refer to as a "playbook", during each therapy session. I understand my physical therapist will train me on how to fill out my playbook and that Sports Center designs my therapy sessions to facilitate learning on my part to ensure I will be successful in the long term after completing my therapy at Sports Center.

Client Signature: ___________________________________ **Date:** ______/______/_________

Authorization to Communicate

I give permission to Sports Center to contact me by phone or email with appointment reminders, including leaving messages at home or work. I give permission to Sports Center to contact me with birthday cards, holiday related cards, and information about treatment alternatives or other health related information, including a practice newsletter. I give permission to receive thank you messages for referrals.

Client Signature: ___________________________________ **Date:** ______/______/_________

No Show / Cancellation Policy

We charge a $50 fee for no shows and appointments cancelled with less than 24 hours notice. We will kindly waive the fee if you can make the appointment up within one business day of the original appointment.

If you don't show up or cancel too late, of course that hurts you because you don't get what you need, but it also hurts us. We won't have adequate time to fill the appointment. So, please call us if you can't make your appointment at least 24 hours ahead of time.

I have read and understand Sports Center's No Show / Cancellation Policy.

Client Signature: ___________________________________ **Date:** ______/______/_________

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Insurance Verification and Financial Policy

I understand and agree that my health insurance policy is a contract between my insurance carrier and myself. I understand that Sports Center will prepare the necessary reports and forms to assist me in collecting payment from my insurance company and that any amount authorized to be paid directly to Sports Center or its physical therapists for services rendered will be credited to my account upon receipt. I permit Sports Center to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, the fees for physical therapy services rendered to me will be immediately due and payable.

IMPORTANT: We contact your insurance company to determine your benefits as a courtesy to you. You are ultimately responsible for knowing your benefits. If the information provided to us from your insurance company is ever incorrect, the resultant bill is still your responsibility.

Cash Clients:

- Full payment is due at the time of service.
- We accept MC, Visa, Discover, Amex, debit cards, checks, and exact cash (no change).
-

Private Insurance Clients:

Our relationship is with you, not your insurance company. As a service to you, we will submit claims to your primary insurance correctly one time. You are responsible for payment of the services and products rendered to you. **If your insurance has not paid in full within 45 days, per date of services, you are responsible for the bill and for attempting to reimburse yourself.** We expect payment within 15 days of you receiving your statement from Sports Center.

- ***Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Insurance claims are filed as a courtesy to you. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-pays, co-insurance, and/or coverage disputes other than to supply factual information as necessary. You are responsible for the timely payment of your account.***
- ***Any charges not covered by your insurance company due to medical necessity, policy limitations, policy maximums, modality maximums, usual and customary guidelines and/or the difference between benefits verified and the benefits paid are your responsibility.***
- ***We do not file claims for Medicare, Medicaid, automobile injuries, and any injuries associated with litigation.***

Client Printed Name:________________________________

Client Signature: ___________________________________ **Date:** ______/______/_________

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Receipt of Notice of Privacy Practices

I understand that as part of my care, Sports Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination / test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning care and treatment**
- **A means of communication among the health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third party can verify that services billed were provided**
- **A tool for routine healthcare operations (i.e. assessing quality and competence of healthcare professionals)**

I understand that I can request, at any time, a copy of Sports Center's Notice of Privacy Practices that provides a more complete description of my healthcare information uses and disclosures. I understand that I have the following rights and privileges:

- **The right to review the notice prior to signing this consent**
- **The right to request in writing restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.**

I understand that Sports Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Sports Center has already taken action in reliance thereon.

I further understand that Sports Center reserves the right to change their notice and practices. When changes are made, a new Notice of Privacy Practices will be posted and reasonable attempts will be made to inform clients of changes. I understand I may request a copy of Sports Center's Notice of Privacy Practices at any time.

I understand that Sports Center may request medical records, special test reports such as MRI, X-Ray, bone scans, CT scans, etc., and other relevant clinical information from other medical providers involved in my care as verbally authorized by me for my initial consultation and/or therapy sessions to help in understanding my complaints and designing a treatment program for me.

Please contact our Privacy Officer with any questions, concerns, or complaints regarding our privacy practices.

I have read and understand this document. I also understand that I can request a full copy of Sports Center's Notice of Privacy Practices at any time.

Client Signature: ___________________________________ **Date:** ______/______/_________

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