New West Orthopaedic and Sports Rehabilitation

General Information

Patient Name: _____ DOB: _____ Gender: M F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Phone #: (H)_____(C)_____SSN: _____ Married? Y N

Employer: _____(W) _____ Email: _____ Appt. Reminders? Y N

Emergency Contact: _____ Phone #: _____ Relationship: _____

Insurance Information

Primary Insurance Name: _____ Policy Holder: _____ DOB: _____

Secondary Insurance Name: _____ Policy Holder: _____ DOB: _____

Additional Information (For patients on their parent's insurance plan or patient's under the age of 19)

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

Mother's Phone #: _____ Father's Phone #: _____

City/State/Zip: _____ City/State/Zip: _____

Mother's Employer: _____ Father's Employer: _____

Employer's Phone #: _____ Employer's Phone #: _____

Mother's SSN: _____ Father's SSN: _____

Guarantor of Account?Yes / No Guarantor of Account? Yes / No

Patient Health History

Height: _____ Weight: _____ Age: _____ Family Physician: _____

Please mark if you have ever had:

- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Blood Disorders
- ❑ Multiple Sclerosis
- ❑ Cancer
- ❑ Parkinson's disease
- ❑ Seizures/epilepsy
- ❑ Thyroid problems
- ❑ Skin disease
- ❑ Heart Problems
- ❑ Lung Problems
- ❑ High blood pressure
- ❑ Infectious disease
- ❑ Kidney problems
- ❑ Repeated infections
- ❑ Depression
- ❑ Broken bones
- ❑ Muscular dystrophy
- ❑ Stroke
- ❑ Head Injury
- ❑ Allergies
- ❑ Circulation problems
- ❑ Diabetes
- ❑ Low blood sugar
- ❑ Ulcer
- ❑ Hepatitis
- ❑ Other: _____

List of allergies: _____

Surgeries, Fractures, Major illnesses/injuries	Year

Medications	Dosages

Are you pregnant or think you may be pregnant? Yes / No Do you have a pacemaker? Yes / No

Current Condition(s)/Chief Complaint(s)

Injury Area: _____

Date of Injury: _____

Type of injury: Sports / Employment / Vehicle / Other

How did the injury occur: _____

_____

List date of last procedure related to injury:

Surgery: _____ Location: _____

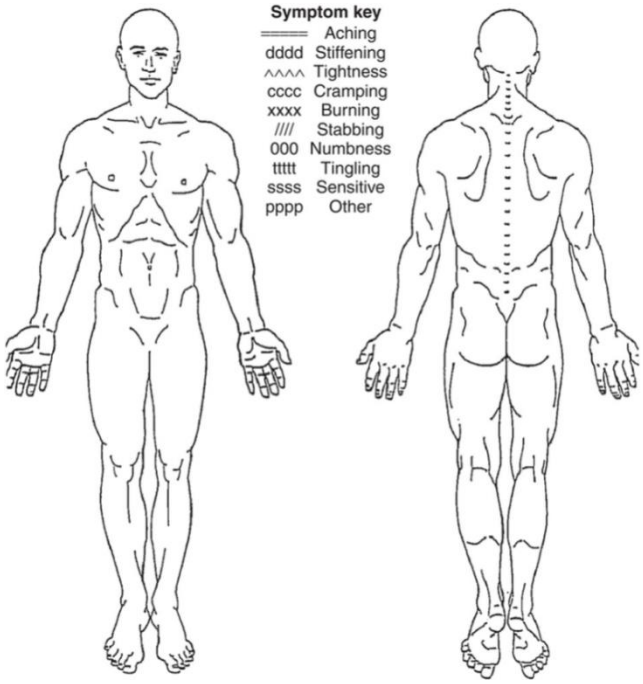
MRI: _____Location:_____

X-Ray: _____ Location: _____

Referring Physician: _____

Please rate the intensity of your pain on a scale of 0 to 10, 0 being no pain and 10 being the worst pain possible

Today: _____ Best: _____ Worst: _____ Activities that cause pain: _____



_____ _____ _____

Patient or Guardian Signature **Date** **Relationship**

Patient Financial Policy

Please initial next to one of the following payment agreements

_____Health Insurance Carriers:
I am covered an insurance plan and hereby authorize all payments go directly to New West Orthopaedic and Sports Rehabilitation. I agree to pay the amount my insurance plan indicates I am responsible for at the time of service. I agree to provide written authorization prior to my receiving treatment if this is required by my insurance plan. Covered benefits vary between insurance plans. Some insurance plans require pre-authorization for therapy services. Therefore, make sure have pre-authorized your treatment, if necessary. Additionally, it is your responsibility to understand the limitations and exclusions of your policy. If you have any questions regarding your coverage, please contact your plan administrator or the insurance company's customer service department.

_____ **Medicare:** I am a Medicare recipient, and understand New West Orthopaedic and Sports Rehabilitation accepts assignment of Medicare claims. The Medicare Physical Therapy/ SLP cap for 2017 is $1980 per year. I understand that New West Orthopaedic and Sports Rehabilitation will file my claims for me to both my Medicare and secondary insurance.

_____ **Medicaid:** I am covered by Medicaid and verify that my coverage is active. If my eligibility status changes I will let New West Orthopaedic and Sports Rehabilitation know. I understand that if I am seen without coverage I am responsible for the charges incurred. Should my Medicaid plan have a co-pay or deductible requirement, I agree to make payment the time of service.

_____ **No Insurance:** I have no assignable third party coverage and New West Orthopaedic and Sports Rehabilitation will not file an insurance claim for my services. We ask that you remit payment within ten days of receiving your monthly statement. We are happy to accept payments by cash, check, or credit card. If your account reaches 90 days past due and you have not contacted us to make a payment arrangement, your account may be turned over to our collection agency.

_____ **Law Suit/Liability:** Our policy is to file liability claims on behalf of our injured patients. However, if denial is received or if your claim is not settled within six months, we will ask that you begin to make regular monthly payments. Failure to make these payments may result in your account being turned over to a collection agency. We can also submit to your health insurance for payment at your request as one as the information is provided to us. We will work with you to establish a reasonable monthly payment plan to accommodate your needs. If an attorney is involved, we will file a lien with them, but this is no way releases your responsibility in making required monthly payments. . ****Fill out Liability Form**

_____ **Workers Compensation:** I have a work related injury. New West Orthopaedic and Sports Rehabilitation will bill my employer for the services rendered, and in the event of a dispute with my employer about the work-relatedness of my injury, I accept full responsibility for payment of my account, I will provide a copy of my person health insurance card to New West Orthopaedic and Sports Rehabilitation. ****Fill out WC Form**

Please initial all five lines below:

_____ Consent to Treat: I understand that by initializing I am giving permission for evaluation and treatment by New West Orthopaedic and Sports Rehab and that I have the right to refuse any procedures after having the risks and benefits explained to me.

_____ Assignment of Benefits: I herby authorize New West Orthopaedic and Sports Rehabilitation to furnish information to the above-named insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance.

_____ Medical Authorization: I hereby authorize release of any and all medical records to New West Orthopaedic and Sports Rehabilitation. I also consent to the release of my health care records to be reviewed by my insurance company or any necessary audits within New West Orthopaedic and Sports Rehabilitation.

_____ HIPAA Notice of Privacy Practice: I acknowledge that New West Orthopaedic and Sports Rehabilitation has offered or supplied me with a copy of their HIPAA Notice or Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to New West Orthopaedic and Sports Rehabilitation to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

_____ Monthly Statement: I acknowledge that a Patient Account Statement will be sent at the end of the month from New West Orthopaedic and Sports Rehabilitation @ 2810 W 30th Street, Suite #2, Kearney, NE 68845. If you have any questions regarding your statement feel free to call the clinic at (308) 237-7388.

_____	_____	_____
Patient or Legal Guardian Signature	Date	Relationship

HIPAA Agreement

I have reviewed this practice practices form and hereby acknowledge that I have read and understand the privacy practices of New West Orthopaedic and Sports Rehabilitation.

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient

By this form I give permission to New West Orthopaedic and Sports Rehabilitation to discuss my medical condition with the following people:

Spouse: _____

Parents: _____

Children: _____

Other Family Members: _____

Caregivers: _____

Guardian: _____

Close Personal Friends: _____

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship to Patient