PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

PATIENT INFORMATION

LAST NAME:	FIRST:	MIDDLE:	BIRTHDATE: / /	AGE:	SEX: ☐ M ☐ F
CURRENT ADDRESS:			SOCIAL SECURITY:	HOME PHONE: ( )	
CITY:	STATE:	ZIP CODE:	BILLING ADDRESS (if different):		
MARITATL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER			SPOUSE'S NAME:		
OCCUPATION:			EMPLOYER/SCHOOL NAME:	EMPLOYER PHONE: ( )	

REFERRING PHYSICIAN INFORMATION

DOCTOR'S NAME:	PHONE NUMBER: ( )	ADDRESS/CLINIC NAME:

REASON FOR TODAY'S VISIT

BODY PART/HOW INJURY OCCURRED:	
IS THIS INJURY/CONDITION RELATED TO ☐ WORK ☐ CAR ☐ HOME ☐ OTHER: _____	DATE OF INURY / 1ST SYMPTOMS

IF PATIENT IS A MINOR

NAME OF GUARANTOR:	BIRTHDATE / /	RELATIONSHIP

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

NAME (Last, First, Middle):	RELATIONSHIP:	HOME PHONE: ( )	DAY PHONE: ( )

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and health care institutions as is necessary to my care and treatment. By signing below, I agree to consent to care by Proliance Sports Therapy.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE:

PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

Patient Financial Responsibilities

Proliance Sports Therapy and Rehabilitation, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance Sports Therapy and Rehabilitation.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your estimated portion of the charges at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Visits – Visits must be paid in full at the time of service. In return, we offer you a 20% discount. This discount does not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $_____ deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge a $10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Sports Therapy and Rehabilitation or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

_____

Patient or Legally Authorized Individual Signature Date

PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

PROLIANCE SURGEONS®

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

_____ _____

Signature of Patient or Guardian Date Time

_____

Printed Name

PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

AUTHORIZATION TO LEAVE PERSONAL INFORMATION BY ALTERNATE MEANS

Patient Name: _____ Date of Birth: _____

Please check all that apply:

- ☐ May leave detailed message on voicemail at home # _____
- ☐ May leave detailed message on voicemail at work # _____
- ☐ May leave detailed message on my cellular phone # _____
- ☐ May leave detailed message at different location # _____
- ☐ May leave detailed message with spouse (Name) _____
- ☐ May leave detailed message with other family member (Name) _____
- ☐ May send detailed message by e-mail to: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____

Patient or Legally Authorized Individual Signature Date

PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

MEDICAL INTAKE / PATIENT QUESTIONNAIRE

Name: _____ **Date of Birth:** ____/____/_____

Area of Injury: _____ **Side of body:** ☐ L ☐ R **Hand Dominance:** ☐ L ☐ R

Date of Injury: _____ **Date of Surgery:** _____

How did the Injury Occur: _____

Briefly describer your symptoms (what makes it better / worse, what it prohibits you from doing, etc.)

_____

_____

Have you ever had physical/occupational therapy or other treatment for this problem? (chiropractic, acupuncture, braces/splints, etc.) **If yes, please describe**:

_____

_____

Relevant operative or invasive procedures and/or injuries:

_____

_____

Diagnostic Testing: ☐ X-Ray ☐ CT Scan ☐ EMG

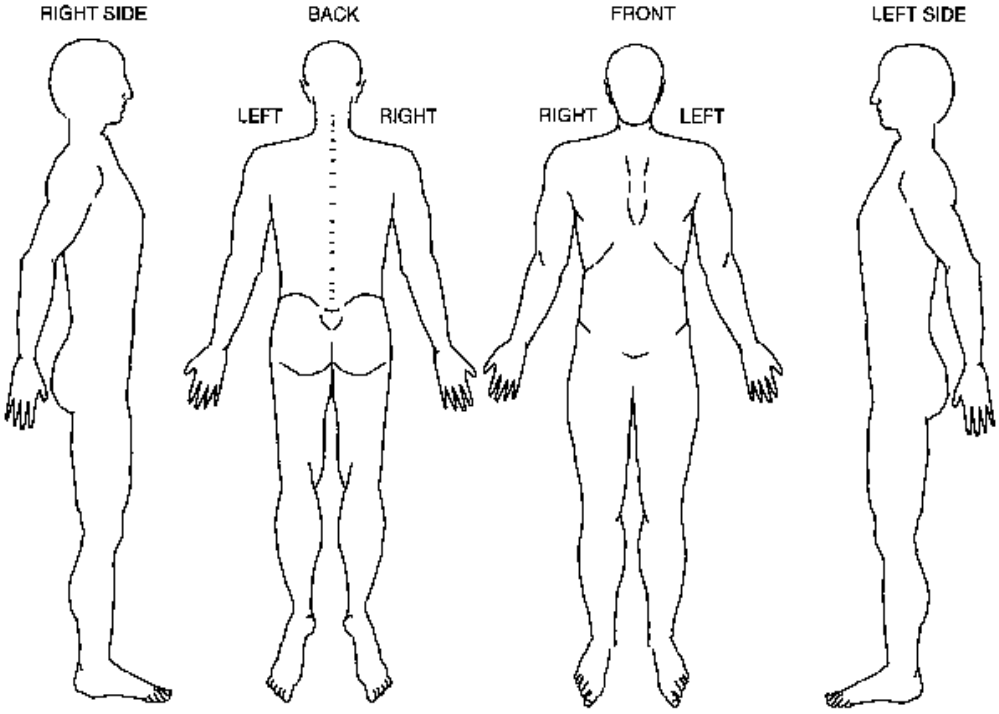
Results (if known): _____

_____

Please rate your pain level on a scale from 0 to 10. Circle the appropriate number. Use the diagram to circle any problem areas where you have experienced pain in the last week.

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

(No Pain) (Moderate Pain) (Severe Pain)



PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

Please indicate if you have, or have ever had, the following conditions:

☐ Heart Disease	☐ Gout	☐ Osteoarthritis
☐ Lung Disease	☐ Neurologic Disorder	☐ Rheumatoid Arthritis
☐ Cancer	☐ Depression	☐ Asthma
☐ High Blood Pressure	☐ Kidney Disease	☐ Osteoporosis
☐ Stroke	☐ Liver Disease	☐ DVT (Blood Clots)
☐ Diabetes	☐ Thyroid Condition	☐ Pacemaker
☐ Seizures	☐ Hepatitis	☐ Other: _____
☐ Irregular Heart Rate	☐ AIDs/HIV	

Do you have any metal implants or artificial joints? ☐ Yes ☐ No

Are you currently taking steroid medication? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No

Are you or could you be pregnant? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

What is your works status?

☐ Full Duty	☐ Light Duty	☐ Out of Work
☐ Student	☐ Retired	☐ Disability
☐ Restrictions	☐ Part Time	☐ Other

What are your job duties/responsibilities? _____

Please list your current medications: _____

_____

_____

Allergies: _____

What are your personal goals during physical therapy? (e.g., return to work, resume a recreational activity, dress yourself, negotiate stairs, etc.)

_____

_____

_____

_____

Date of the next physician's visit: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____