



Patient Intake

<div style="border: 1px solid black; padding: 2px;">1 PATIENT INFORMATION</div> <p>PRO Sports Club Member <input type="checkbox"/> Y <input type="checkbox"/> N 20/20 Client <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____ Patient: _____ Address: _____ City: _____ State: _____ Zip: _____ E-mail address: _____ <input type="checkbox"/> It is OK to contact me by email regarding Physical Therapy or Podiatry Sex: _____ Age: _____ Birth date: _____ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced Patient SS# _____ Occupation _____ Employer _____ Spouse's Name _____ Birth date _____ SS# _____ How did you hear about us? _____</p>	<div style="border: 1px solid black; padding: 2px;">2 INSURANCE</div> <p>Who is the primary cardholder for this account? _____ Relationship to Insured: _____ Insurance Co. _____ Group # _____ ID # _____ Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Co. _____</p> <p>ASSIGNMENT AND RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to PRO Sports Club all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practitioner to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.</p> <p style="text-align: right;">Signature _____</p> <div style="border: 1px solid black; padding: 2px; text-align: center; font-weight: bold;">CO-PAYMENTS ARE DUE AT TIME OF SERVICE</div>
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3 PHONE NUMBERS

Home: _____ Work: _____ Alternate: _____
 Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____
 Home _____ Work _____ Extension _____

<div style="border: 1px solid black; padding: 2px;">4 MEDICATIONS</div> <p><input type="checkbox"/> No current medications</p> <p>Include prescriptions, over-the-counter medications and vitamins _____ _____ Pharmacy Name(s) _____ Pharmacy Phone(s) _____ Do you take oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<div style="border: 1px solid black; padding: 2px;">5 ALLERGIES</div> <p><input type="checkbox"/> No known allergies</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Adhesive/Tape</td> <td><input type="checkbox"/> Local Anesthetics</td> </tr> <tr> <td><input type="checkbox"/> Anticoagulant Therapy</td> <td><input type="checkbox"/> Novocain</td> </tr> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/> Penicillin</td> </tr> <tr> <td><input type="checkbox"/> Codeine</td> <td><input type="checkbox"/> Seafood</td> </tr> <tr> <td><input type="checkbox"/> Demerol</td> <td><input type="checkbox"/> Sulfa</td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td></td> </tr> </table> <p>Other _____ _____</p>	<input type="checkbox"/> Adhesive/Tape	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Anticoagulant Therapy	<input type="checkbox"/> Novocain	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Seafood	<input type="checkbox"/> Demerol	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Iodine	
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6**MEDICAL HISTORY**

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medicine or Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foot or Leg Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves or Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in Ankles, Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Surgeries you have had _____

Hospitalizations other than for the surgeries listed _____

Family Physician _____ Last visit date _____

Are you now, or have you been, under any other practitioner's care for any reason over the past two years? Yes No

If yes, please explain _____

7**CANCELLATION POLICY**

Dear Valued Patient:

We at PRO Sports Club strive to provide the best possible care for our patients. This includes our commitment to a schedule that allows adequate time with each individual being treated. There is a time on the schedule reserved specifically for you. In order to provide proper individual time with patients, we appreciate and expect you to be on time for your appointment. We require a 24-hour cancellation notification so that we may provide another individual with the opportunity of coming in at your appointment time to receive care. To minimize the occurrence of late cancels and no-shows, **should you miss an appointment or arrive more than 10 minutes late, and are unable to be seen. A \$40 dollar fee will be billed immediately. Your insurance company will not pay this charge.** Thank you for your cooperation.

I have read and understand the above policy:

Signature _____ **Date** _____

8**CONSENT**

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

Patient's Signature _____ **Date** _____

(FOR OFFICE USE ONLY):

Reviewed (initials) _____ Date _____ Reviewed (initials) _____ Date _____

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HIPAA Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and Services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the PRO Sports Club, whether made by your personal treating practitioner or others working within PRO Sports Club. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For Treatment
- For Payment
- For Check in at the front desk for non-members
- For Health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health Risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others

Your rights regarding Health Information about you:

- Rights to Inspect and copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this notice (full notice is available upon request)

Changes to this Notice:

We reserve the right to change this notice. We will retain a copy of the current notice in our facility.

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location or department you were treated to file a complaint.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of a copy of the notice of Privacy Practices of PRO Sports Club

Patient or Personal Representative Signature

Date

Please include the names of persons with whom we are allowed to discuss your medical condition and/or billing information.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

I authorize PRO Sports Club to discuss my billing and or medical condition with the above named person(s).

Patient or Personal Representative Signature

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