PT:	DR:	RX:_			
PATIENT REGIS	TRATION FORM				
Name:	MI	T	Ω ,		
First	MI	Last	Spouse's name		
Address:		City	Zip		
Date of Birth:		•	Home Phone:		
Employer:Nam	ne	Address	Phone #		
Occupation:		Sc	Social Security #:		
Spouse's Employer	:				
	Name	Address	Phone #		
In case of emergence	cy notify:				
	Name	Phor	ne # Relation		
Insurance Company	y Name		Insured's Name		
Insurance Address		City	Zip		
Group #/Name		Insured's I.D. #	Date of Injury/Surger		
Is this condition a r		Compensation Injury? hicle Accident?	Y N Y N		
the release of any inform	nation provided on this forn	n for the purpose of completing	o Sports Therapy Associates, Inc. and authorize g insurance forms. I agree to pay for the services which I have received a copy.		

Today's Date

Signature

GENERAL MEDICAL HISTORY

Name Primary Treat	ting Physician_	
List Medications that you are taking for your current Anti-Inflammatories Pain Medications Muscle Relaxants Other List Any Other Medications You Are Taking	condition:	Other Physicians Cardiologist Neurologist Internal Medicine
Have You Ever Experienced Any of The Following Symptom Yes No Angina Asthma Blood Clot Cancer Chest Pain Diabetes Severe Depression Drug Allergies Hyper/Hypotension Heart Attack	Metal Implants Osteoporosis Seizures Severe Headac Shortness of B: Spinal Pain Pacemaker Stroke Ulcer Do You Smoke Are You Pregn	Yes No Hes reath e?
If there is any other condition not covered above which you below	u feel would assi	ist us in your care please feel free to list
Not including Your Current Condition, Have you had ANY	Y surgeries in the	e last 3 years (please explain)
Have You Had Any Hospitalizations in the last 3 years (ple	ease explain)	
Do you have any litigation pending your current condition Additional Comments	Yes	No

OFFICE FINANCIAL POLICY

Steve Mutto, R.P.T. and staff would like to welcome you to SPORTS THERAPY ASSOCIATES, INC.

We find that communication with our patients regarding our financial policy is helpful before beginning a course of physical therapy. We are happy to bill your insurance company each week with our computerized billing system, provided you have supplied us with the necessary information to do so.

As most insurance companies cover a specific percentage for physical therapy services, your particular percentage of responsibility will be verified and you will only be billed for the amount, which has been stated. Please be aware, that there is no guarantee of how much your insurance company will cover until the claims are received and processed.

Occasionally insurance companies require additional information in order to process claims. In these cases, we appreciate the cooperation of our patients. Please do not hesitate to contact our office should you require our assistance in billing matters or if you have any questions whatsoever. We are happy to help you.

I, as patient or guardian of a minor, understand that I am financially responsible for all charges regardless of insurance coverage.					
Signature					

Sports Therapy Associates, Inc.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Sports Therapy Associates, Inc.'s Notice of Information Practices. I understand that Sports Therapy Associates, Inc. may use of disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sports Therapy Associates, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sports Therapy Associates, Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name		
Signature		
Date		