PT:_____ DR:_____ RX:_____

PATIENT REGISTRATION FORM

Name:_____
First MI Last Spouse's name

Address:_____
City Zip

Date of Birth:_____ M____ F____ Home Phone:_____

Employer:_____
Name Address Phone #

Occupation:_____ Social Security #:_____

Spouse's Employer:_____
Name Address Phone #

In case of emergency notify:_____
Name Phone # Relation

_____
Insurance Company Name Insured's Name

_____
Insurance Address City Zip

_____
Group #/Name Insured's I.D. # Date of Injury/Surgery

Is this condition a result of: 1) Worker's Compensation Injury? Y_____ N_____
2) Motor Vehicle Accident? Y_____ N_____

I, the undersigned as patient or legal guardian of a minor patient, assign benefits to Sports Therapy Associates, Inc. and authorize the release of any information provided on this form for the purpose of completing insurance forms. I agree to pay for the services rendered in accordance with the terms set forth in the financial policy of this office which I have received a copy.

_____
Signature Today's Date

GENERAL MEDICAL HISTORY

Name_____ Primary Treating Physician_____

List *Medications* that you are taking for your current condition:
Anti-Inflammatories_____
Pain Medications_____
Muscle Relaxants_____
Other_____

Other Physicians
Cardiologist_____
Neurologist_____
Internal Medicine_____

List Any Other Medications You Are Taking

_____
_____
_____

Have You Ever Experienced Any of The Following Symptoms or Been Treated for (last 10 years)

	Yes	No		Yes	No
Angina	_____	_____	Metal Implants	_____	_____
Asthma	_____	_____	Osteoporosis	_____	_____
Blood Clot	_____	_____	Seizures	_____	_____
Cancer	_____	_____	Severe Headaches	_____	_____
Chest Pain	_____	_____	Shortness of Breath	_____	_____
Diabetes	_____	_____	Spinal Pain	_____	_____
Severe Depression	_____	_____	Pacemaker	_____	_____
Drug Allergies	_____	_____	Stroke	_____	_____
Hyper/Hypotension	_____	_____	Ulcer	_____	_____
Heart Attack	_____	_____	Do You Smoke?	_____	_____
Kidney Problems	_____	_____	Are You Pregnant?	_____	_____
Liver Problems	_____	_____			

If there is any other condition not covered above which you feel would assist us in your care please feel free to list below

_____

Not including Your Current Condition, Have you had ANY surgeries in the last 3 years (please explain)

_____
_____

Have You Had Any Hospitalizations in the last 3 years (please explain)

_____
_____

Do you have any litigation pending your current condition Yes _____ No_____

Additional Comments_____
_____

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 Date

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