



**RETURNING PATIENTS:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

\*Sex: M / F \*Social Security #: \_\_\_\_\_ \*Phone #: \_\_\_\_\_

\*Please **update any information that has change**. If **NO CHANGES**, check off here:  Proceed to next section.

Address: STREET \_\_\_\_\_ APT# \_\_\_\_\_ Phone #: \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ Best Contact #: \_\_\_\_\_

\*Name of CURRENT INSURANCE? : \_\_\_\_\_ \* Marital Status: \_\_\_\_\_

**\*FOR MEDICARE PATIENTS ONLY\***

Are you receiving home health care currently/recently?  YES  NO \*If yes, from what dates? \_\_\_\_\_ to \_\_\_\_\_

**\*INJURY INFORMATION:**

Where's the injury located? \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Surgery Date (if any): \_\_\_\_\_

\*Is the injury due to:  Auto Accident  Work Related  Other: \_\_\_\_\_ \*Referred by \_\_\_\_\_

**\*HEALTH HISTORY (please circle any that apply) :**

Irregular Heart Beat	Chronic Bronchitis	Pacemaker	Heart Surgery	Heart Attack	Asthma	Cancer	Arthritis
Bleeding Disorders	Kidney Disorders	Osteoporosis	Emphysema	Hay Fever	Angina	Seizures	Smoker
Heart Valve Problem	High Blood Pressure	Emphysema	Other Problems/ Surgeries/ Broken Bones - _____				

Diabetes - \*Do you take insulin? \_\_\_\_\_ \* How often do you take glucose? \_\_\_\_\_ Gastrointestinal Disorder - Type: \_\_\_\_\_

**Cancellation / No Show Policy:**

Please call our facility with a **24 hour** notice if you need to change or cancel your appointment. You will be responsible for a **\$25 cancellation fee** after each cancellation unless your appointment is rescheduled for the same or next day. **I am aware of Summit's cancellation policy:**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Financial Responsibility:**

I assign all medical benefits and authorize my insurance carrier(s) to issue payment directly to Summit Sports & Spinal Physical Therapy and/or my therapist. I understand that Summit will bill my insurance carrier(s) directly for services rendered, however, if the insurance carrier(s) should deny responsibility for these claims, I understand I will be held responsible. Failure to pay bills in a timely manner will result in a 40% account increase to compensate Summit for collection agency fees. I further authorize the release of my physical therapy records to insurance companies in order to process claims.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Privacy Practices:**

This acknowledgement reflects the privacy standards set forth by the Department of Health and Human Services. A copy of Summit Sports & Spinal Physical Therapy's privacy practices is located at the front desk. You may also request a copy for yourself.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_