NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS _____
(MAILING)

_____
(CITY) (STATE) (ZIP)

HOME PHONE # _____ CELL PHONE # _____ *
SOCIAL SECURITY #: __ __ __ - __ __ - __ __ __ EMAIL ADDRESS _____ *

***We do our appointment reminders by either email or text**
please indicate your preference:Text___Email___

BIRTHDATE ___ / ___ / ___ AGE ___ MALE___ FEMALE ___ SINGLE __ MARRIED __WIDOWED __
OCCUPATION _____ WORK PHONE # _____
EMPLOYER _____
SPOUSE'S OR PARENT'S NAME _____
SPOUSE'S OR PARENT'S EMPLOYER _____ WORK # _____
PARENT'S ADDRESS (if different than above) _____
_____

PRIMARY CARE PHYSICIAN _____ PHONE # _____
REFERRING PHYSICIAN _____ PHONE # _____

NAME OF NEAREST RELATIVE (not living with you) _____
RELATIONSHIP _____ RELATIVE'S PHONE # _____
DATE OF ONSET _____ INJURY DATE _____ or SURGERY DATE _____
WAS YOUR INJURY CAUSED BY AN AUTO ACCIDENT? YES _____ NO _____
IS AN ATTORNEY INVOLVED? YES _____ NO _____ NAME OF ATTORNEY _____
IS YOUR INJURY COVERED BY WORKER'S COMPENSATION (WC)? YES _____ NO _____
WC CARRIER _____

HAVE YOU BEEN TO THIS OFFICE BEFORE? YES ____ NO _____ WHEN _____
HOW DID YOU HEAR ABOUT US? Newspaper ___ Magazine ___ Radio ___ Friend ___ Doctor ____
WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

We require 24 hours notice if you are unable to keep your appointment. Last minute cancellations and failures to attend scheduled appointments are costly. You will be charged $20 for un-cancelled appointments. Insurance companies will not pay for these NO SHOW fees. You will be responsible for these charges. Please call well in advance if you are unable to keep an appointment.
I hereby authorize treatment by my Physical Therapist.
SIGNATURE _____ DATE _____

By providing us with your land line or cell phone number(s), you give express authorization to contact you at those numbers. This express authorization also applies to any land line or cell phone number(s) you may acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number(s) is not a condition of receiving our services.
SIGNATURE _____ DATE _____

As a courtesy we will bill your primary insurance. All co-payments, non-covered insurance benefits, including deductibles and co-insurance percentages are the patient's responsibility. These, as well as all Direct Pay payments are due at the time of service.
I understand that I am responsible for all charges incurred during my treatment. If my insurance has not paid within 90 days of treatment, I agree to pay the unpaid balance. I also agree to pay for any attorney fees that may be incurred due to the collection of my account. **Signature not required for WC patients.**

SIGNATURE _____ DATE _____

The Center for Sports Medicine

"Physical therapy the right way."

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION & NOTICE OF PRIVACY PRACTICES.

Assignment of Benefits

I hereby instruct and direct _____ Insurance Company to pay by check made payable to and mailed to:

The Center for Sports Medicine & Rehabilitation
1169 Hilltop Parkway, Unit 202B
Steamboat Springs, Colorado 80487

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

Consent of Release of Information

I also authorize the release of any information pertinent to my case to any physicians, rehabilitation consultants, insurance company, adjuster, or attorney involved in this case, except for: _____

Signature_____ Date_____

Acknowledgement of Notice of Privacy Practices

I, _____, have received a copy of the Notices of Privacy Practices for The Center for Sport Medicine & Rehabilitation, PC.

_____ Date _____
Signature of Patient

_____ Date _____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign the form)

_____
Relation of Patient Representative to Patient

☐ Patient refused to sign.