

Personal Information

Date _____

Patient Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

SSN _____ Birth Date _____ Age _____

Circle appropriate one: single married divorced widowed separated

Occupation _____ Employer _____

Work Phone _____ Physician _____

Responsible Party

Name of person responsible for this account _____

Billing Address _____ City _____ State _____ Zip _____

Relationship to patient _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Name of Employer _____ SSN of Insured _____

Insurance Company _____

Address _____ City _____ State _____ Zip _____

Group Number _____ Claim Number _____

Billing Policy

SOAR, Inc and Therapy Works, Inc., while sharing the same location, are separate and distinct businesses and as such will generate their own billing. As a courtesy to you, your insurance company will be billed as long as all appropriate information has been provided. However, it should be kept in mind that your insurance contract is an agreement between you, the insured, and the insurance company. You, the insured, will be held fully responsible for any amount that the insurance company does not pay. Any account with an outstanding balance over 90 days will also be charged a 1.5% per month finance charge. This is an annual percentage rate of 18%.

I understand and agree to the above billing policy.

Signature _____

Date _____

Do you presently have or have you had any of the following:

	YES	NO	
Diabetes	_____	_____	_____
Hypoglycemia	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease/Attack	_____	_____	_____
Angina or chest pain	_____	_____	_____
Pacemaker	_____	_____	_____
Chronic Headaches	_____	_____	_____
Kidney Problems	_____	_____	_____
Liver Disease	_____	_____	_____
Ulcers/stomach problems	_____	_____	_____
Blood Disease	_____	_____	_____
Anemia	_____	_____	_____
Thyroid Problems	_____	_____	_____
Nerve System Disorder	_____	_____	_____
Seizures	_____	_____	_____
Stroke	_____	_____	_____
Dizziness	_____	_____	_____
Hernia	_____	_____	_____
Cancer	_____	_____	_____
Respiratory Problems	_____	_____	_____
Shortness of breath	_____	_____	_____
Osteoporosis/Osteopenia	_____	_____	_____
Joint Pain	_____	_____	_____
Fibromyalgia	_____	_____	_____
Allergies	_____	_____	_____
Metal Implants	_____	_____	_____
TMJ Problems	_____	_____	_____
Previous Surgery	_____	_____	_____

Women: Are you pregnant? Yes No Maybe

If this visit is because of an injury give date: _____

Please list any medications that you are presently taking:

_____	_____
_____	_____
_____	_____
_____	_____

Name: _____

Date _____

Patient Consent for the Use and Disclosure of Health Information

I understand that as part of my health care, Sports & Orthopedic Assessment & Rehabilitation, Inc. (SOAR, Inc.) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that SOAR, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SOAR, Inc. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should SOAR, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity such as an medical billing service, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline (circle one) the terms of this consent.

Patient's Name (Print)

Patient Signature (or Guardian)

Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____.

[] Consent refused by patient, and treatment refused as permitted.

[] Consent added to the patient's medical record on _____.