PATIENT INFORMATION

Name: _____ Gender: M ☐ F ☐ DOB _____

Address:	City:	State:	Zip:
Email:	Emergency Contact Name:		
Mobile#:	Emergency Contact Phone:		
Home#:	Emergency Contact Relationship to You:		

INSURANCE INFORMATION

Primary Insurance:	Subscriber Name:

NOTE: If you are not the policy subscriber, do you carry other insurance? YES ☐ NO ☐ If YES, who is your other insurance carrier?

EMPLOYER INFORMATION

Employer:	Job Title:	Work#:	
Address:	City:	State:	Zip:

INFORMATION ABOUT YOUR INJURY

Is this a work related injury? YES ☐ NO ☐ If YES, who is your W.C. Carrier? _____

What is your Claim#? _____

Is this due to an auto accident? YES ☐ NO ☐ If YES, your self-pay payment will be required at the time of service.

Whom shall we thank for this referral?

Doctor:		Friend:		Other:	

FOR OFFICE USE ONLY:

DX _____ PT _____ ACCT. TYPE _____

REFERRING MD _____ EVALUATION DATE _____

Patient Health Questionnaire

Patient Name: _____ **Date of Birth:** _____

Occupation/Work Activities: _____ Sports/Hobbies: _____

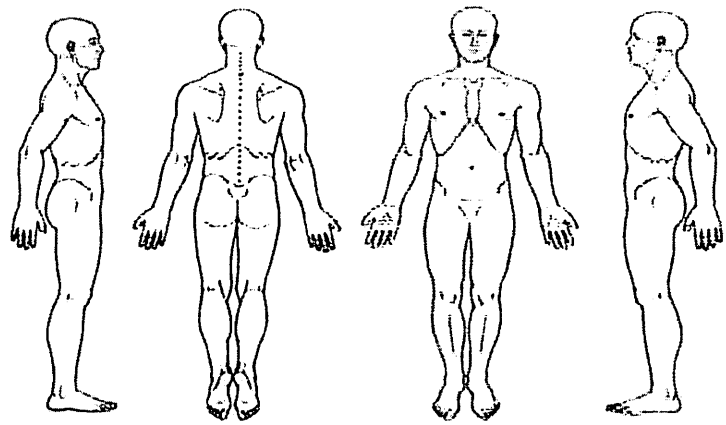
1. **Describe the injured area(s) and your current symptoms:** _____

   _____

   a. When and how did your symptoms start? _____

   b. Have you had similar symptoms in the past? ☐Yes ☐No

2. **How often do you experience your symptoms? Print, then mark where you have pain or other symptoms on the body chart.**
   - ○Constantly (76-100% of the day)
   - ○Frequently (51-75% of the day)
   - ○Occasionally (26-50% of the day)
   - ○Intermittently (0-25% of the day)



3. **Circle what describes the nature of your symptoms?**
   - ○Sharp ○Shooting
   - ○Dull ache ○Tightness
   - ○Numb ○Tingling
   - ○Burning ○Stiffness

4. **How are your symptoms changing?**
   - ○Getting Better
   - ○Not Changing
   - ○Getting Worse

None Unbearable

5. **Circle the average intensity of your symptoms during the past week:** ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

6. **Please indicate the level (0-10) of your pain at *Best*:** _____ ***Worst*:** _____

7. **In general, would you say your overall health right now is...**

   ○Excellent ○Very Good ○Good ○Fair ○Poor

8. **Please list all of your current medications:** _____

9. **Please check the box if you have a history of any of the following:**

☐High blood pressure	☐Arthritis (osteo/rheum.)	☐Numbness/tingling
☐Heart problems	☐Tuberculosis	☐Weakness
☐Lung problems	☐Kidney Disease	☐Bowel/bladder problems
☐Liver problems	☐Headaches	☐Gout
☐Gall bladder problems	☐Thyroid	☐AIDS
☐Stroke	☐Mental Illness	☐Hepatitis
☐Seizures	☐Sudden weight gain/loss	☐Women's health issues
☐Osteoporosis/Osteopenia	☐Nausea/vomiting	☐Depression
☐Diabetes	☐Night fever/chills/sweat	☐Chemical/alcohol dependency
☐Cancer	☐Fatigue	☐ Pacemaker
		☐Other: _____

10. **Who have you seen for these symptoms?**

    ○No one ○Medical Doctor ○Chiropractor ○Acupuncturist ○Physical Therapist

Patient Signature _____ **Date** _____

Insurance Billing and BaySport Policies

BaySport, on your behalf, will bill your primary insurance for services rendered. We will also accept Flex Spending or HSA cards. **We do not bill secondary insurance.** However, we can provide you with *super bills* so that you can bill your secondary insurance yourself.

Deductibles, copayments and coinsurance are due at the time of service. Should your insurance deny your claims, you will be responsible for payment.

It is your responsibility to provide complete insurance information. You need to present your current insurance card at you first visit. To best serve you and your health needs, we must always have a current copy of your card for our files.

It is your responsibility to know your insurance benefits and any plan limitations your carrier may have. Please contact your insurance company and ask them about your benefits.

It is also important to remember that health insurance coverage varies and not all services are covered. If your insurance carrier rejects a claim or approves only a portion of the amount billed, the balance of the claim is your responsibility.

MAXIMUM VISIT LIMIT

Many Insurance plans have a maximum number of visits allowed which include Occupational Therapy, Speech Therapy and Physical Therapy combined. Please check with your plan to ensure that you have not reached your benefit maximums for these services. _____
initial

PAYMENT GUARANTEE

In consideration of the services rendered and to be rendered to the above named patient by BaySport Inc., I expressly guarantee payment of the account and agree to pay any charges left unpaid in whole or in part or determined to be not medically necessary by the insurance company. _____
initial

RELEASE OF INFORMATION

I give permission to BaySport Inc. to release information to other healthcare providers, my insurance company, attorney, assignees and/or beneficiaries. _____
initial

ASSIGNMENT OF BENEFITS

I authorize payment directly to BaySport, Inc. for Physical Therapy services I receive. _____
initial

CANCELLATION POLICY

We respectfully request a 24-hou notice of cancellation. If you have an emergency and cannot provide a 24-hour notice, please call as soon as possible. BaySport reserves the right to charge you a $75.00 fee for failing to comply with this policy. The $75.00 fee is due at the next scheduled visit. _____
initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BaySport, Inc. reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for BaySport Inc. _____ Go to http://www.baysport.com/docs/PrivacyPractices.pdf to BaySport's Privacy Practices.
initial

I have read and understand the preceding information.

X_____ / / _____
Signature of patient or person responsible for patient Date

X_____
Print Name

Waiver of Claims for BaySport Facility Usage:

There may come a time when the BaySport patients' transition from one-on-one treatment to selected individual activities within the BaySport clinical facility. The patient expressly agrees that use of all facilities – exercise equipment, exercise machines is undertaken by the patient at his/her sole risk. The patient further agrees that BaySport, Inc. is not liable for injuries or damages to any patient while using these facilities.

The patient agrees that BaySport is not subjected to any claim, demand, injury or damages whatsoever, including, without any limitation to those damages resulting from acts of active or passive negligence, except for the sole negligence or willful misconduct, on the part of BaySport, their owners, officers, agents, or employees. The patient, for himself/herself and on behalf of his/her executors, administrators, heirs assigns and successors does hereby expressly forever release and discharge BaySport, its owners, officers, employees, agents, assigns and successors from all such claims, demands, injuries damages, actions or causes of action. The patient agrees that BaySport is not responsible or liable to patients for articles damages, lost or stolen in the clinic, or in lockers. Patients agree not to store any valuable items in lockers and to use the lockers provided solely for temporary clothing storage.

Rules and Regulations: BaySport patients may use the clinic facilities only at the time of the scheduled appointment.

Attire: All participants using the clinic must wear proper exercise attire. All patients must wear proper footwear.

Acknowledgement: The undersigned states that he/she has read and understands the terms and conditions of the Agreement, agrees to be bound by such terms and conditions and acknowledges that he/she has received a copy of this Agreement.

Signature of Patient Date

BaySport Representative Date