PIONEER SPINE AND SPORTS PHYSICIANS – PATIENT REGISTRATION

Last Name:_______________________First Name:_______________M.I.___DOB:___/___/____

Age:_______ Soc. Sec. #:_______-______-________ Sex: M ( ) F ( )

Address:_______________________ City:____________________ State:______ Zip:__________

Home Phone:( ) ___________________ Work Phone: ( ) ______________________

Cellphone:_______________________ E-Mail:______________________________________

Emergency Contact:_________________Relationship:________ Phone #: ( )_______________

Employer: ____________________________________ Phone#: ( )_________________________

Workers Compensation Case ( ) M.V.A./Auto Accident ( )

Date of Injury: _____________________ Date of Accident: ___________________

BILLING INFORMATION

Primary Insurance:____________________ I.D. #:____________Group #:______________

Please fill out the following by placing a check next the correct answer ( )

Are You Participating In Physically Handicapped Childrens Program: Yes ( ), No ( )

Student Status: Full Time ( ), Part Time ( ), Not A Student ( )

Race: American Indian/Alaska Native ( ), Asian ( ), Black/African American ( ),
Native Hawaiian/Other Pacific Islander ( ), White ( ), Other ( ),
Patient Declined/Unknown ( )

Ethnicity: Hispanic/Latino ( ), Not Hispanic/Latino ( ), Patient Declined/Unknown ( )

Patient's Primary Language: English ( ), Spanish ( ), Arabic ( ), Polish ( ), Portuguese ( ),

Russian ( ), Vietnamese ( ), Patient Declined/Unknown ( ), None ( ) Other:_______________

(Continued On Back)

CONSENT FOR TREATMENT

I authorize PIONEER SPINE & SPORTS PHYSICIANS and/or their designee to examine, treat and perform any diagnostic testing or certain procedures in the office deemed necessary to properly evaluate my condition.

____ Date:_______/________/_________
Patient or Empowered Representative

ASSIGNMENT OF BENEFITS

I authorize release of medical information necessary to process any and all claims for services rendered to me by PIONEER SPINE & SPORTS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. I authorize payment of any and all benefits to be made on my behalf to the office of PIONEER SPINE & SPORTS PHYSICIANS. I understand that I am financially responsible for all charges. I have read this information and I understand its contents.

____ Date_______/________/__________
Patient or Empowered Representative

MISSED APPOINTMENT POLICY

If you miss an appointment and do not cancel the appointment ahead of time, this may be considered a "no show." Any missed appointment may be subject to a $20.00 missed appointment fee.

____ Date______/_______/____________
Patient or Empowered Representative

Attorney's Name (if applicable)

___________________________Address:__________________________________

Phone:_____________________________

Pioneer Spine and Sports Physicians

PHYSICAL THERAPY – PATIENT INFORMATION

Name: _____________________________ Male ___Female ___ Today's Date: _____________

Date of Birth: _________ Age: ____ M.D. Name: _____________ Next M.D. Visit __________

Please check current work status: Full ___ Restricted Duty __ Unable to Work ____ N/A ______

Type of Work/Occupation: ____

Injury Date and Cause: ____

Primary Complaint: ____

Previous Injuries To This Area: ____

Previous or Current Treatment/Surgeries For This Problem: ______________________________

____

Diagnostic Tests: ____

PAST MEDICAL HISTORY (please check either Yes or No next to each item)

Yes	No		Yes	No	
____	_____	Heart Disease/Irregular Heartbeat	_____	______	Cancer
____	_____	Circulatory Problems	_____	______	Diabetes
____	_____	High Blood Pressure	_____	______	Gynecological Problems
____	_____	Lung Disease	_____	______	Osteoporosis
____	_____	Kidney/Gallbladder Problems	_____	______	Fractures
____	_____	Liver/Jaundice/Hepatitis	_____	______	Headaches
____	_____	Gastrointestinal/Ulcers	_____	______	Visual Problems
____	_____	Bowel/Bladder	_____	______	Anemia
____	_____	Thyroid	_____	______	Immune System Suppression
____	_____	Neurological (i.e. Stroke, Seizure)	_____	______	Metal Implants
____	_____	Automobile Accidents	_____	______	Arthritis
____	_____	Females: Any Chance of Pregnancy?			

Medications: ____

Allergies to Medications: ____

Patient Signature: ____________________________________ Date: ___________________

Continued on next page

Current activity level: ____

Please indicate which activities and how long you are able to perform those activities before having to stop (within the last two weeks)

______ Standing	_______ Squatting	_______ Lying on Stomach/Back/Side
______ Sitting	_______ Kneeling	_______ Turning in Bed
______ Driving	_______ Reaching Overhead	_______ Writing/Typing
______ Slow Walk	_______ Bending/Lifting	_______ Gripping/Opening Jar
______ Fast Walk	_______ Putting on Socks/Shoes	_______ Turning a Key
______ Running	_______ Up/Down Stairs	_______ Other (Including Sports)

Is sleep disturbed? Yes ____ No ____ Please Explain: ____________________________

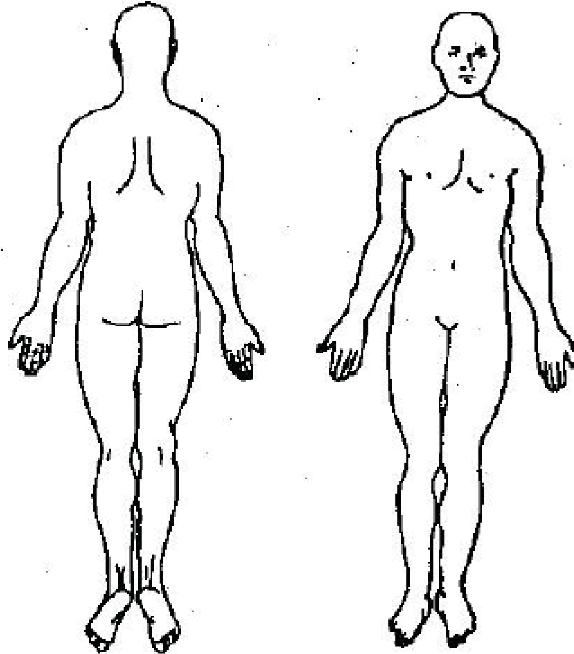
Do you have numbness/tingling/burning? Yes ______ No _______ Where? ________________

What brings on pain? _______________________ What eases pain? ______________________

Is Pain: Constant? __ Off and On? ___ Weakness: Yes ___ No ___ Where? ______________

Pain Scale: Please circle pain at lowest: 0 1 2 3 4 5 6 7 8 9 10 (Emergency)
Please circle pain at highest: 0 1 2 3 4 5 6 7 8 9 10 (Emergency)

Please shade areas of pain:



Your goals for P.T.: ____

____

Patient Signature: _____________________________________ Date: __________________

Phone Number: ____________________________

DETACH THIS PAGE FOR YOUR RECORDS

ATTENTION PATIENTS

Many insurance companies require that referrals and authorizations be in place prior to treatment being rendered.

It is the responsibility of the patient to call their primary care physician for any referrals, or to call their insurance company with any prior notification that is required. If the referral is not in place at the time of your visit, you will be asked to sign a waiver if treatment is rendered.

If your insurance requires authorization after your initial evaluation, you will not be scheduled for any follow-up appointments until we have received authorization for your future visits.

If you have any questions, please feel free to call the Physical Therapy Department.

Thank you,

Pioneer Spine and Sports Physicians

OUTPATIENT SCHEDULING INFORMATION SHEET

- After your initial visit, you will receive a schedule of appointments.
- It is your responsibility to participate and attend all scheduled appointments.
- If you are unable to attend an appointment you **MUST** notify PSSP Physical Therapy at (413) 785 – 5777. We urge you to call **24 HOURS** prior to your scheduled appointment if you would like to cancel. The secretary will either reschedule or confirm your next appointment.
- If you are <u>more than 15 minutes late</u> for your appointment, the attending therapist reserves the right to <u>cancel</u> your appointment if he/she deems necessary.
- If you miss an appointment and do not cancel the appointment ahead of time, this will be considered a **"no-show"**. You will be subject to a $20.00 missed appointment fee.
- If you **"no-show"** for <u>two consecutive appointments,</u> you will be discharged.
- If you **"no-show"** for <u>a total of three appointments,</u> you will be discharged.
- If you **cancel** for <u>a total of four appointments,</u> you will be discharged.
- When you are discharged under the above conditions, the following will be notified in writing:
  Your physician
  Your insurance company
  Your attorney
  Your workman's compensation carrier
  All other parties involved.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I UNDERSTAND THAT THE PURPOSE OF REGULAR ATTENDANCE WILL ALLOW ME TO GAIN MAXIMUM BENEFIT FROM THERAPEUTIC INTERVENTION.

PATIENT SIGNATURE: ________________________________ DATE: ________________

PIONEER SPINE AND SPORTS PHYSICIANS, P.C.

HIPAA CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Pioneer Spine and Sports Physicians (PSSP) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Pioneer Spine and Sports Physicians (PSSP). I understand that diagnosis or treatment of me by Pioneer Spine and Sports Physicians (PSSP) may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations is not required to agree to the restrictions that I may request. However, if Pioneer Spine and Sports Physicians (PSSP) agrees to a restriction that I request, the restriction is binding on Pioneer Spine and Sports Physicians (PSSP) and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pioneer Spine and Sports Physicians (PSSP) has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Pioneer Spine and Sports Physicians' Notice of Privacy Practices prior to signing this document. The Pioneer Spine and Sports Physicians' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Pioneer Spine and Sports Physicians. The Notice of Privacy Practices (PSSP) is also provided in waiting rooms. This Notice of Privacy also describes my rights and the Pioneer Spine and Sports Physicians' duties with respect to my protected heath information.

Pioneer Spine and Sports Physicians (PSSP) reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Pioneer Spine and Sports Physicians' office.

______________________________________ ________________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority