PALM COAST SPORTS MEDICINE AND REHAB CENTER, INC.

35 Old Kings Rd. N

Palm Coast, FL 31237

Tele: 386-445-5555

PATIENT INFORMATION FORM

First Name MI Last Name	Home Phone #	Work/Cell #
Home Address	City & State	Zip Code
Mailing Address	City & State	Zip Code
Spouse Name	Home Phone #	Work/Cell #
Last 4 digits of SS #	DOB	SEX Male ( ) Female ( )
Physician Name & Address		Phone #
Emergency Contact		Phone #
Primary Insurance		Primary Insurance
Address		Address
City & State Zip Code		City & State Zip Code
Policy #		Policy #
Phone #		Phone #

Who is financially responsible for this bill?

I will be paying by CASH CHECK CREDIT CARD

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

WE REQUIRE A 24 HOUR NOTICE FOR CANCELLATION OF AN APPOINTMENT. A NO SHOW FOR YOUR SCHEDULED APPOINTMENT WITHOUT SAID NOTIFICATION WILL RESULT IN A $45 SERVICE FEE. BY SIGNING BELOW. I HAVE READ AND UNDERSTAND THE NO SHOW POLICY.

Patient Signature Date

Parent Signature for Minor Date

Palm Coast Sports Medicine
Medical History Form

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

Patient Name:_____ Date:_____
Reason for therapy:_____ Date of Injury:_____
Is this injury a result of an accident? Yes_____ No_____ If yes, Explain:_____
_____

1. Circle all that apply and explain the following medical problems that you have had:

AIDS/HIV	Drug Abuse	Liver Disease
Allergies	Emphysema	Motor Vehicle Accident
Anemia	Fainting	Psychiatric Treatment
Arthritis	Fractures	Rheumatic Heart Disease
Asthma	Glaucoma	Seizures
Back Trouble	Heart Disease	Shortness of Breath
Bronchitis	Heart Attack	Sinusitis
Cancer	Heart Murmur	Stomach Ulcers
Chest Pain	Hepatitis	Stroke
Congenital Heart Defect	Herpes	Swelling of Hands/Feet
Congestive Heart Failure	High Blood Pressure	Thyroid Disease
Convulsions	Jaundice	Tuberculosis
Diabetes	Kidney Disease	Rheumatic Fever
Bleeding Disease		

2. List and operations or surgeries that you have had:_____
_____
_____
3. List and medications you are currently taking:_____
_____
_____
4. List and allergies and describe any drug reactions:_____
_____
_____

5. Please circle any of the following you have/wear:

Glasses/Contacts	Artificial Joints	Pacemaker	IUD
Metal/Foreign Object Implants		Wires/Screws/Nails	

6. Are you pregnant? Yes_____ No_____
7. Any significant weight gain/loss in the last year? Yes_____ No_____ (+-)_____ lbs
8. Have you had Physical, Occupational, or Speech Therapy before? Yes_____ No_____
   If yes, for what condition were you treated for?_____

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.

Signature:_____ Date:_____

Palm Coast Sports Medicine & Rehab Center, Inc.

Patient Consent Form

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of your notice may change, if we change our notices, you may obtain a revised copy by contacting our office.

You have the right to request the we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this for, you consent to our use and disclose of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Palm Coast Sports Medicine provides this form to comply with the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

_____(Initial)

Patients Rights and Responsibilities

By signing this form, I understand my rights and responsibilities as a patient. If you desire a copy of my patient rights and responsibilities, the front desk will provide one for you.

_____(Initial)

Conditions of Admissions

RELEASE OF INFORMATION: This agency may disclose all of any part of the patient's records to any person or corporation which is or may be liable under a contract to the agency or to the patient or to the family member or employer of the patient for all of part of agency's charge, including but not limited to, hospital or medical service companies, insurance companies, workman's compensation carrier's, welfare fund, or the patient's employer.

FINANCIAL RESPONSIBILITY: I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers. The undersigned certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms. I understand that unpaid balances are subject to a $50.00 a month late fee.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless for any insurance company's arbitrary determination or usual and customary rates. Our providers are here to present you with the best medical care. Their primary concern is your health and well being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

_____(Initial)

_____

Responsible Party/ Patient or Patient's Agent Signature

_____

Date

_____

Witness

Palm Coast Sports Medicine & Rehab, Inc

Assignment of Benefits Form

I, _____, understand that services rendered to me by Palm Coast Sports Medicine are my financial responsibility and that the provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to Palm Coast Sports Medicine and I understand that I will be fully responsible for any outstanding balance on my account. 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.

I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Palm Coast Sports Medicine within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Palm Coast Sports Medicine to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____

Signature of Policyholder

_____

Date

_____

Witness