OFFICE HOURS & APPOINTMENTS

Monday - Thursday: 7:00 am - 7:00 pm
Friday: 7:00 am - 5:00 pm

Your first appointment will be an initial evaluation, which is required by state law. This allows your therapist to determine your treatment plan.**We recommend scheduling follow-up appointments in advance for 2+ weeks** to best accommodate your schedule.

CANCELLATION POLICY

We schedule patients to provide quality care and offer you the best possible treatment. Our hours of operation are flexible to accommodate our patient's schedules with varying treatment days and times. We understand things may come up. We ask that if you need to cancel or reschedule your appointment to contact us at least **24 hours in advance**. Failure to do so will result in a **fee of $65** that will be added to your account to be paid prior to your next visit. Your insurance will not cover this charge.

Appointments changed to a different time slot on the same day of service if available will NOT be charged a fee. We commit to provide a high standard of care and ask that you commit to your scheduled appointments.

ADMINISTRATIVE FEE

Our primary goal at the Sports Rehabilitation Center is to put the needs of the patients first. We accomplish this goal by providing the most skilled Physical Therapists and seeing a low volume of patients (1-2/hour) to ensure that you have adequate one-on-one time with your therapist.

Due to changes in healthcare and insurance reimbursement, we implement an "administrative/supply" fee of **$3 per visit.** This fee is to maintain our current low volume model and to provide the highest quality care despite increased overhead from supply costs**.** This fee is not covered by insurance and is separate from your co-payment.

CHANGE OF INFORMATION

It is important that we have current patient information in our records. Please advise the front office staff of **any changes of address, phone number, insurance information, etc**. that may have occurred.

I have read, fully understand, and abide by the Sports Rehabilitation Center policies. **By signing below, you are verifying that you have read and agree to ALL policies stated above.**

Signature: ____ Date: _________
Patient OR Personal Representative

Printed Name: ____

MIDTOWN	DUNWOODY	BROOKHAVEN	SANDY SPRINGS
555 10TH ST	5342 TILLY MILL RD	2669 OSBORNE RD NE	5290 ROSWELL RD, #W
ATLANTA, GA 30318	DUNWOODY, GA 30338	ATLANTA, GA 30319	ATLANTA, GA 30342
PH-404.477.8888	PH-770.395.2643	PH-404.477.7777	PH-404.477.5555
FAX-404.477.8889	FAX-770.393.4374	FAX-404.477.7000	FAX 404.477.5556

MEDICAL RECORDS

Your medical records are held in the strictest confidence. If you would like information about your medical condition to be provided to a third party, other than your referring physician, a written authorization signed by you will be required.

I hereby assign all medical benefits to which I am entitled to the Sports Rehabilitation Center of Brookhaven in the event that they file insurance on my behalf and I authorize said assigned to release all information necessary to secure the payment of said benefits. I am aware that I am financially responsible for all charges whether or not paid by said insurance. **A copy of this assignment shall be considered as effective and valid as the original.**

FINANCIAL/ INSURANCE INFORMATION

We will file claims with your primary insurance carrier. When we verify insurance, we strive to obtain as much information as possible. However, insurance companies often only disclose a certain amount of information to us “the provider”. Insurance companies may also have “per visit” limits or may “not cover” specific charges. We encourage you to verify the specifics of your policy with your insurance company in order to clarify exactly what is covered, not covered,etc.

You are ultimately responsible for your bill and will need to pay the full amount of your bill until your deductible is met, then the percentage of charges not covered by your primary insurance carrier will be collected on a daily basis.

PRIVACY PRACTICES

We are required by federal and state law to maintain the privacy of your health information. We use and disclose health information about you for treatment, payment and healthcare operations. You have the right to look at and get copies of your health information. You may also give us authorization to use your health information or to disclose it to anyone for any purpose.

The privacy of your health information is important to use. Should you have any questions regarding this abbreviated explanation or request to read the full privacy practice, please ask our front desk.

I have read, fully understand, and abide by the Sports Rehabilitation Center policies. **By signing below, you are verifying that you have read and agree to ALL policies stated above.**

Signature: ____ Date:______________
Patient OR Personal Representative

Printed Name: ____

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CONSENT FOR CARE AND TREATMENT

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Sports Rehabilitation Center, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. We cannot guarantee what your reaction will be to a particular treatment nor can we guarantee that our treatment will help the condition for which you are seeking therapy. You have the right to decline any portion of your treatment at any time.

This consent form proxies us with your permission to perform reasonable and necessary medical/therapeutic examinations, testing, and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuous throughout your plan of care; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

____ **Date:________________**
Signature of Patient OR Personal Representative (under 18)

____
Printed Name of Patient OR Personal Representative (under 18)

PATIENT INFORMATION

PERSONAL

Last Name:______________________ First Name:______________________ Middle Initial:______

Sex: ___ Male ___ Female DOB:_____________ Age:_____ SSN:________________________

Address:________________________________ City:________________ State:_____ Zip:_______

Permanent Address (if different from above):____

Email:_______________________________ Telephone (*Primary Number*): ___________________

Name of Referring Doc: ____

Emergency Contact: _______________________________________ Relationship:_______________

Contact number(s): _______________________________ OR ________________________________

EMPLOYMENT

Employer: _____________________________ Telephone: ________________________________

Job Title: _______________________________ Years of Employment: _____________________

Work Address:______________________________City: ____________ State:_____Zip: _______

INSURANCE INFORMATION

Name of Company: ____________________________ Telephone: ___________________________

Address:_____________________________City:_______________State:_____ Zip:________

ID #:___________________ Group #: ________________________ Claim #:___________________

Primary Insured: _____ Self ____Spouse _____Parent ______ Employer _____Other

Name of Spouse: __________________________ Middle Initial:______ DOB:________________

Address *(if different from above):* ________________________________ State: ____ City:___________ Zip:________

Telephone *(Primary Number)*: ____________________________

Spouse Employer: __________________________ Work Number: __________________________

Job Title:________________ Address:____

Physical Therapy Medical History Intake Form

When did symptoms start (date): ______________

Have you had these symptoms before? ☐ Yes ☐ No

How did symptoms start? ____________________

____

Symptoms are? ☐ Constant ☐ Come/Go ☐ Only with Activity

Symptoms are? ☐ Getting worse ☐ Not changing ☐ Getting better

List any medications or dietary supplements you are taking:

____

____

List any drug or latex allergies you are aware of:

____

List Assistive Devices you use (crutches, braces, shoe inserts):

____

Do you have difficulties with? (check all that apply)

☐ Communication ☐ Speech ☐ None

☐ Vision ☐ Hearing ☐ Other ______________

Medical History:	**Self**	**Family**
Cancer	Yes No	Yes No
Diabetes	Yes No	Yes No
High Blood Pressure	Yes No	Yes No
Osteoporosis	Yes No	Yes No
Osteoarthritis	Yes No	Yes No
Rheumatoid arthritis	Yes No	Yes No
Neurologic dz (MS, Parkinson's)	Yes No	Yes No
Ulcers/GERD/Acid Reflux	Yes No	Yes No
Kidney/Liver Disease	Yes No	Yes No
Prior Surgeries:	Yes No	

Other: ______________________________

In the past 3 months have you had or do you experience?	
Change in your general health	Yes No
Fever/chills/sweats	Yes No
Unexplained weight change (>10lbs)	Yes No
Numbness or tingling	Yes No
Bowel/bladder incontinence	Yes No
Difficulty sleeping due to pain	Yes No
Unexplained falls/decreased balance	Yes No

Are you currently/Do you have:	
Pregnant/Potentially pregnant/Nursing	N/A Y N
Often bothered by feeling down, depressed, or hopeless	Y N
Often bothered by little interest or pleasure doing things	Y N
Under physical/emotional abuse	Y N
Dietary or Nutritional concerns	Y N
Do you use tobacco products	Y N

Mark an "X" on the lines below that best describes your response.

1. Which activity causes you the most pain / most trouble performing?

____

Function: Rate your ability to perform the *above* activity.

0 1 2 3 4 5 6 7 8 9 10
Unable to Perform — No restrictions

2. Pain at WORST: Rate your highest pain level in past 72 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

3. Pain at BEST: Rate you lowest pain level in past 72 hrs.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain Imaginable

4. Impact: How distressing is this condition to you?

0 1 2 3 4 5 6 7 8 9 10
No problem — Devastating

Indicate the location and type of pain on the chart:

Key:
Ache/Dull: ^ ^ ^ ^
Sharp/Stabbing: x x x x
Numb / Tingling: o o o o
Pins & Needles: · · · ·
Burning: = = = =
Throbbing: / / / /
Other Pain: - - - -

Therapist Notes:

NAME: ______________________________ **DATE:** ________________

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