PATIENT INFORMATION

PATIENT'S LEGAL NAME___________________________ **DATE OF BIRTH**__________
First Middle Last

ADDRESS___________________(apt.)___________________________
Street City State Zip Code

HOME PHONE NUMBER (_____)__________ **CELL PHONE NUMBER** (_____)__________

OCCUPATION__________________ **EMPLOYER**__________________

EMAIL ADDRESS____

EMERGENCY CONTACT

WHOM SHALL WE CONTACT IN THE EVENT OF AN EMERGENCY? ___________________________
Name Phone Number

INSURANCE (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

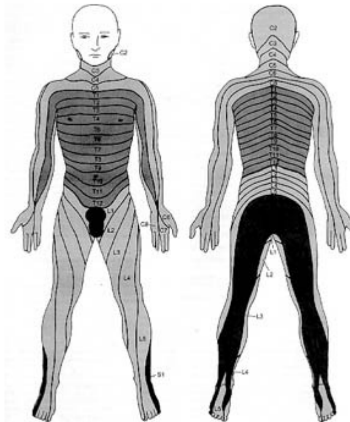
Primary Insurance Type: BCBS MEDICARE HAP PPOM OTHER: __________

Subscribers relationship to patient:______________ subscriber's date of birth__________

NAME OF DOCTOR THAT HAD REFERRED YOU: ___________________________

WHOM MAY WE THANK FOR YOUR REFERRAL TO CLINT VERRAN SPORTS MEDICINE?
Name ___________________________

PLEASE CIRCLE THE AREA THAT NEEDS TO BE TREATED.



WHAT IS YOUR REASON FOR COMING IN TODAY? RIGHT _____ LEFT ______

HOW LONG HAVE THE SYMPTOMS BEEN PRESENT: ___________________________

ADDITIONAL COMMENTS:___________________________
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I, THE UNDERSIGNED, HEREBY UNDERSTAND I AM RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED BY CLINT VERRAN SPORTS MEDICINE, INC NOT COVERED OR PAID BY MY INSURANCE CARRIER. I ALSO UNDERSTAND, AND HAVE READ/SIGNED THE ATTATCHED AUTHORIZATIONS, RELEASES, AND ASSIGNMENTS.

___________________________ ______________
SIGNATURE OF PATIENT / GUARDIAN DATE

*ASSIGNMENT AND PAYMENT RESPONSIBILITY * RELEASES * AUTHORIZATIONS

I, the undersigned, hereby authorize and instruct my insurance company, adjuster, rehabilitation representative, attorney, social worker, employer, any other payer, or myself to pay any and all benefits/monies directly to Clint Verran Sports Medicine, Inc. for any services rendered to me due to accident or illness. In addition, I fully understand I am responsible for any amount not covered by my insurance, and that cash pay services do not necessarily represent the same services as insurance.

Under Major/Master Medical Coverage or any other medical coverage, it is conceivable my insurance company will issue payment directly to me for physical therapy services. As a result, I agree to submit the aforementioned checks accompanied by their vouchers to Clint Verran Sports Medicine, Inc. no more than five (5) days after receiving said payment. Again, I understand full payment of all charges for the physical therapy treatment received at Clint Verran Sports Medicine, Inc. is ultimately my responsibility.

My insurance company, under my Major/Master Medical coverage, may send my checks directly to the Clint Verran Sports Medicine, Inc. address upon submission of paperwork on my behalf. I, the undersigned, give and grant the full power and authority to Clint Verran Sports Medicine, Inc. to accept these payments and credit my account accordingly for the physical therapy treatment provided by Clint Verran Sports Medicine, Inc.

I, the undersigned, hereby authorize Clint Verran Sports Medicine, Inc. to release any and all information relevant to and pertaining to my care and treatment to my physicians, adjuster, social worker, attorney, or rehabilitation representative. Furthermore, I authorize Clint Verran Sports Medicine, Inc. to release any and all information to my insurance companies required pursuant to the processing of my claims.

I, the undersigned, hereby consent to and authorize Clint Verran Sports Medicine, Inc. to administer physical therapy treatment to me for which I am responsible. I have been informed by my physician as to the nature and the purposes for which physical therapy is to be performed and administered by Clint Verran Sports Medicine, Inc. However, I do acknowledge there may be additional procedures as deemed necessary on the basis of findings during the course of said physical therapy treatment. I consent to such procedures after an explanation has been given of their nature and purpose. In addition, I acknowledge results are contingent on my participation in my treatment, though are still not guaranteed.

I, the undersigned, understand I must provide a 24-hour cancellation notice. Failure to comply with this policy will result in a fifty-nine dollar ($59.00) fee.

I certify all information given on my intake forms is accurate.
A photocopy of this authorization shall be acceptable as the original.
I certify that I have read and fully understand the above consents.
(If the patient or insured is a minor, their parent or guardian must sign this form.

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PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

CLINT VERRAN SPORTS MEDICINE, INC.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the Clint Verran Sports Medicine, Inc. Notice of Privacy Policies on the date indicated below.

Signature:____ Date:_______________