Elite Sports Medicine Physical Therapy

Acknowledgment and Authorization

Insurance Co-pays, Deductible, or Co-Insurance
Insured patients are expected to present an insurance card at each visit to determine any changes in insurance eligibility or copay assignments. All insurance co-payments, estimated deductible and/or co-insurance amounts are due and payable upon arrival for your appointment.

Patient Statements
Patient statements are generated and mailed each month on all accounts with an outstanding patient balance. All statement balances are due in full on or before the 20th of the following month unless a formal payment plan has been negotiated and signed. Partial payments will be applied to the patient's account; however, the acceptance of partial payments will not automatically establish a payment plan of any kind and may result in the initiation of our collections process.

Accepted Payment Types
We accept MasterCard, Visa, American Express, Discover, and Care Credit; as well as personal checks, money orders and cash.

Check Acceptance Policy
NSF checks are automatically reprocessed with the addition of a $25 +tax processing fee. In addition to the processing *fee,* the patient account will be charged with any additional bank charges as well as any additional administrative costs associated with the collection and processing of the returned check.

Monthly Payment Solution
Affordable monthly payments can be a reality and enrollment is quick and simple. To learn more about or to enroll in our payment solution, please call our business office during normal business hours. No agreement will be considered or activated without proper documentation and an original signature.

Referrals
If your insurance carrier requires that you be referred to a specialist by your primary care physician (PCP), it is your responsibility to have your PCP obtain the referral prior to your scheduled clinic visit. We will assist you by tracking your referrals, but request your participation and cooperation as necessary.

HIPPA
I have read and understand the HIPPA/Privacy Policy for Elite Sports Medicine Physical Therapy, provided at the front desk. I authorize Elite Sports Medicine Physical Therapy obtain/have access to my medical and medication history.

Medical Records
Copies of your medical records can be obtained for a nominal fee of $25. Medical records sent to third parties at your request require a $25 payment for the first 20 pages and $0.50 per additional page. A Medical Records Release Form authorizing the release of your information must be signed prior to the release of information to a third party. Please allow 14 days for medical records to be prepared. Please refer to our Notice of Privacy Practices in compliance with HIPAA regulations for guidelines on how your personal health information is protected.

Non-Standard Insurance Forms
Upon receipt of a $15 fee, we will complete and file your personal insurance claim forms (FMLA, AFLAC, etc .) Please allow 7 days for forms to be completed, signed and mailed after payment has been received. Each additional form request is treated and billed individually.

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Collection Agency
We retain the service of an outside Collection Agency for recovery of delinquent balances. We reserve the right to attach all additional fees associated with any effort toward collecting the delinquent account balance in its entirety including, but not limited *to,* attorney *fees,* court costs and collection fees imposed by a collection agency (43% of original balance), associated with any effort.

Billing Questions
Patient statements are sent monthly and provide detail about dates of service and balances due. We are always happy to answer any questions or concerns about your billing or statements. Please call our office at 254-732-5981. This Financial Policy helps us provide quality, consistent care to our valued patients. If you have any question or need clarification of any of the above policies, please feel free to contact us. I have read and understood the above policy statement.

Insurance Payments
I hereby assign my insurance benefits to be paid directly to my healthcare provider. I authorize Elite Sports Medicine Physical Therapy to release medical information required to process my claim.

Forms of Contact
I authorize my provider's office to contact me by home, office, or mobile phone in regards to, but not limited to, appointments, test results, billing.

Cancellation/No Show Policy
Due to the limited time slots available for appointments, it is important that all patients attend their appointments as scheduled. If you are unable to attend, it is expected that you call and inform us at least 24 hours prior to your appointment time. If you arrive 10 minutes after your scheduled appointment time, your treatment may be decreased due to the time constrictions. As a policy, if you have 3 or more no-shows, we reserve the right to discontinue services.

Child Policy
If your child is unable to sit quietly beside you and becomes a distraction for others that are receiving care, we will ask to reschedule your appointment for when you have a sitter available. This policy is enforced strictly for promotion of efficient patient care and the atmosphere in the clinic for others.

Consent for Care and Treatment
I, the undersigned, do hereby agree and give consent to Elite Sports Medicine Physical Therapy to furnish medical care to _____ for treatment to include but not limited to in clinic treatment/telehealth visits/E-visits considered necessary and proper in diagnosing or treating their physical and mental condition.

_____ _____ _____

Elite Sports Physical Therapy Health History Questionnaire

Please answer all questions thoroughly

Name _____ **Date of Birth:** ____/____/____
First *MI* *Last*

Social Security Number: _____-_____-_____ Age: _____

Gender: ___ Male
___ Female

HEIGHT: _____
WEIGHT: _____

DOMINANT HAND:
___ LEFT
___ RIGHT

Primary Care Physician: Name: _____
Address: _____
Phone: _____

Referred By: *(Please check one)*

- **Physician:** Name: _____
  Address: _____
  Phone: _____
- **Emergency Room:** Hospital _____
- **Other Health Care Professional** Name & Location _____
- **Physical Therapist** Name & Location _____
- **Coach/Athletic Trainer** Name & Location _____
- **Friend/Patient**
- **Self Referred**
- **Family Member**
- **Other** _____

What Sports are you involved in? *(Please check all that apply)*

___ Football	___Track	___ Powerlifting/Weight lifting
___ Basketball	___ Tennis	___ Cross Country
___ Soccer	___ Volleyball	___ Golf
___ Baseball/Softball	___ Swimming	___ Other_____

Are you a student? _____ Yes _____ No
What school do you attend? _____
What are you studying? _____

Preferred Pharmacy: _____

PAIN DIAGRAM

On a scale of 0-10, how would you describe your pain level at REST?

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, how would you describe your pain level with LIGHT ACTIVITIES?

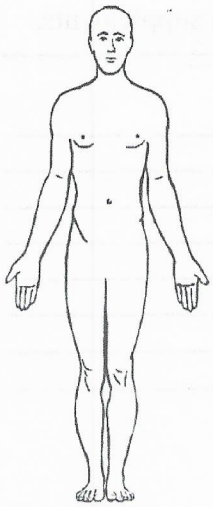
0 1 2 3 4 5 6 7 8 9 10

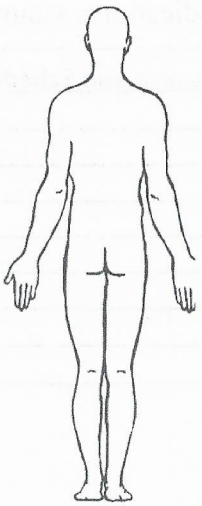
On a scale of 0-10, how would you describe your pain level when at its WORST?

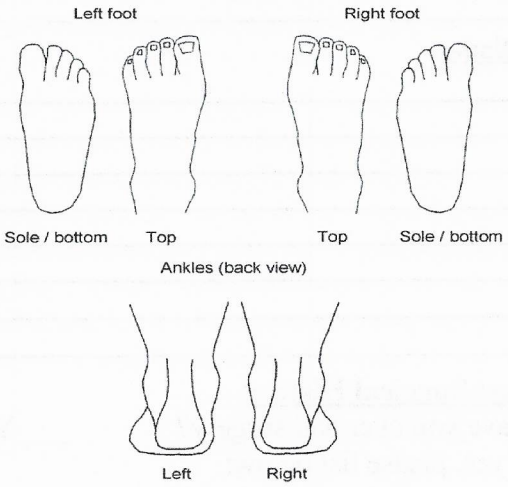
0 1 2 3 4 5 6 7 8 9 10

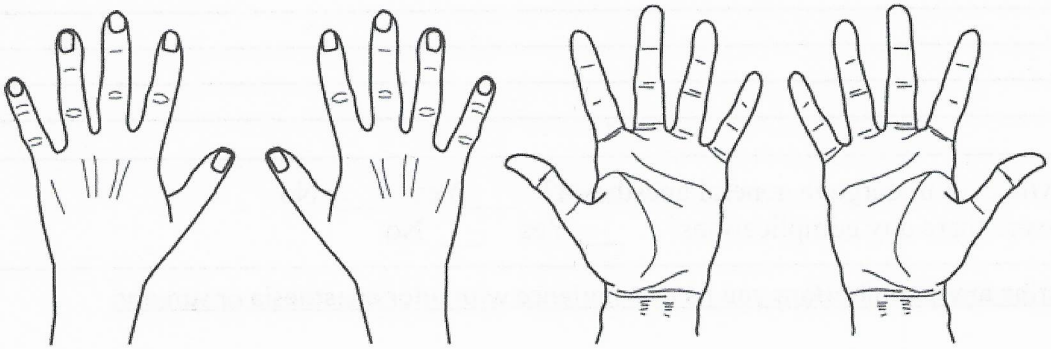
Use the appropriate symbol below to indicate on the drawings, the symptoms you feel. If you are being seen for your foot or hand/wrist, use the diagrams at the bottom.

Pain	Aching	Numbness	Pins & Needles	Burning	Stabbing
XXX	^^^	+++	***	OOO	√√√









Patient Name: _____ DOB: _____

General Medical History:

Are YOU affected by any of the following? *(Please check all that apply)* __ No Medical Problems

___ Abnormal heart rhythm
___ Alcoholism
___ Anemia
___ Anorexia/Bulimia
___ Anxiety
___ Asthma
___ Bleeding disorders
___ Blood Clots
___ Bronchitis
___ Cancer (*where*_____)
___ Depression
___ Diabetes
___ Emphysema/COPD
___ Endometriosis
___ Fibromyalgia
___ Gout
___ Heart attack
___ Heart failure
___ Hepatitis
___ High blood pressure
___ HIV
___ Irritable bowel
___ Kidney failure
___ Kidney stones
___ Liver Disease
___ Other: _____
___ Lung disease
___ Osteoarthritis
___ Osteoporosis
___ Ovarian Cysts
___ Rheumatoid arth.
___ Seizures
___ Sleep Apnea
___ Stents
___ Stomach Ulcers
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Urinary Tract Inf.

Review of Symptoms

Are YOU experiencing any of the following? *(Please circle ALL that apply)*

General
Unexplained weight loss
Change in appetite
Fever, chills, sweats
Marked fatigue
Difficulty sleeping
Bowel/bladder changes

Eye, Ear, Nose, Throat
Difficulty swallowing
Hoarseness
Nasal Congestion
Hearing loss
Glasses/Vision problems

Cardiovascular
Heart or chest pain
Abnormal heartbeat
Poor heart function
Poor circulation

Lungs
Morning cough
Shortness of breath
Productive cough

Skin
Frequent rashes
Swollen ankles
Frequent itching
Easy bruising

Digestive
Nausea or vomiting
Stomach pain/ulcers
Heartburn
Frequent diarrhea
Frequent constipation
Blood in Stool

Female
Post-menopausal
Pregnant

Neurological
Seizures
Blackouts/fainting
Tremor
Headache/Migraine
Difficulty with balance

Musculoskeletal
Joint pain/swelling
Back Pain
Muscle Aches

Psychiatric
Depression
Anxiety

Hematologic
Hemophilia
Other Blood disorder

Elite Sports Physical Therapy
5100 Franklin Ave, Suite C
Waco, TX 76710
Office (254) 732-5981
Fax (254) 754-2667

Admission Date: _____ DOB:_____ Patient Name: _____

Insurance Company: _____

Patient Responsibility:

Copay per visit: $_____

Estimated Deductible per visit: $IE:_____

$TX:_____

Estimated Co-Insurance per visit: $ _____

You will be responsible for paying at each visit the amount listed to the left. If there is a balance after the insurance has processed the claim we will bill you the difference.

Per Visit Self-Pay Agreement per visit: $_____

Number of Visits Authorized Per Year: _____ Number of Visits Remaining: _____

Maximum Therapy Limit ($):_____ Amount Used of ($):_____

Confirmed with patient by (Elite Employee): _____

Please read and sign the disclaimer below:

The information above has been recorded based on the benefits and eligibility supplied to us by your insurance carrier and is not a guarantee of payment or benefits. Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangement for payment of your estimated share be made today. If payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Elite Sports Medicine Center. The above does not apply for those patients considered Worker's Compensation; however, as a Worker's Compensation patient you may be held responsible for your charges in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Elite Sports Medicine Center, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

If further therapy is required beyond the above authorization period, I will follow-up to make sure that any additional authorization has been obtained from the insurance carrier prior to any additional treatment, if this required by my insurance company. If I incur rehabilitation without appropriate authorization from my carrier, I will be responsible for the charges in full as well as any non-covered services. I will also be liable for all treatment that exceeds what is allowed by my insurance plan. It is my responsibility to ensure this information remains valid throughout my treatment.

_____Signature of Patient or Responsible Party Date: _____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give consent to Elite Sports Medicine Physical Therapy to furnish medical care to _____ for treatment to include but not limited to in clinic treatment/telehealth visits/E-visits considered necessary and proper in diagnosing or treating their physical and mental condition.

_____ Patient/ Guardian Signature Date: _____

Elite Sports Physical Therapy
5100 Franklin Ave, Suite C
Waco, TX 76710
Office (254) 732-5981
Fax (254) 754-2667

Medical Records Release Form

Attention: (Physician/Medical Facility):

From
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

By signing this form, I authorize you to release confidential information about me, by releasing a copy of my medical records or a summary of private or narrative of my protected health information, to the person(s) or entity listed above.

To
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

_____ Any/All records pertaining to OR Date(s) of Treatment/Care requested: _____
(check) _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.
Date: _____

Patient Signature (or parent, guardian or legal representative):

_____ _____
Signature Date

_____ _____
Printed Name D.O.B

I understand that you will provide this information within 15 days from receipt or request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

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For patients who provide a cell phone number a text message reminder will be sent as a courtesy to you to serve as a reminder of your upcoming appointments. This service is not intended to replace direct communication to our office for cancelation of appointments. You must contact our office or your missed appointment will be considered a **no call no-show.**

Child Policy

If your child is unable to sit quietly beside you and becomes a distraction for others that are receiving therapy, we will ask to reschedule your therapy for when you have a sitter available. This policy is enforced strictly for promotion of efficient patient care and the atmosphere in the clinic for others.

I have read and understand this policy.

Patient Name (printed) _____

Signature:_____ Date:_____