

Please fill out BOTH sides COMPLETELY in order to process claims to your insurance company.



Patient Information

Email Address _____		Date / / _____
Patient Name _____		Age _____
Mailing Address/PO Box _____		
City _____	State _____	Zip _____
Phone Home () _____	Phone Work () _____	Cell () _____
Birthdate / / _____	Sex M F _____	
Emergency Contact/ Guardian _____		Phone # _____
Address of Contact/ Guardian (if different) _____		
City _____	State _____	Zip _____

Billing Information

Primary Insured's name _____		
Birthdate / / _____	Name of Employer _____	
Mailing Address/PO Box of responsible party _____		
City _____	State _____	Zip _____

Accident Information

Name of Referring Physician _____	
Date last seen by Physician / / _____	Date of Injury / / _____
Surgery? Y N / _____	Date of Surgery / / _____
Accident Type _____	

If Workers Comp	
Date of Injury / / _____	
Employer _____	Contact person _____
Employer Address _____	
Adjuster _____	Claim _____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Alpine Sports Medicine to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian _____	Date / / _____
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Benefit Assignment/Release of Information

I, hereby assign all medical and /or surgical benefits to include major medical benefits including Medicare, Medicaid, private insurance and third party payers to Alpine Sports Medicine. A photocopy of this information is to be considered valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Financial Policy Statement

We bill your insurance carrier solely as a **courtesy to you**. You are responsible for the entire bill when the services are rendered. Payments, such as copays are expected at the time of service. **Be advised** that payment by your insurance carrier is subject to plan provisions **and is not a guarantee of payment**. Our monthly statements reflect the same information sent by your insurance company. For your benefit you should review your EOB's (Explanation of Benefits) in order to understand our monthly statements. As a patient you are responsible to know and understand your outpatient physical therapy benefits. The above does not apply for those patients that have been authorized by Workman's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting the balance owed.

The above information has been explained to me and I understand my responsibility for the payment of my account.

Patient/Guardian _____	Date / / _____
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Patient Medical History

Are you currently taking any prescription or non-prescription medications? Y N

If yes, please list _____

Have you had any of the following medical or rehabilitative services for this injury? Check all that apply.

- | | |
|---|------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> EMG |
| <input type="checkbox"/> CT Scan | |

Other _____

Please check any conditions that apply

- | | |
|--|---|
| <input type="checkbox"/> Asthma, Bronchitis or Emphysema | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Poor Vision/Hearing | <input type="checkbox"/> Shortness of Breath/Chest Pain |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Energy Loss |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Neck/Injury Surgery |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Elbow Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Leg/Ankle Pain |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Are you Pregnant? |
| <input type="checkbox"/> Sleeping Problems/Difficulties | <input type="checkbox"/> Sulfa Drug Allergy |
| <input type="checkbox"/> Recent Falls | <input type="checkbox"/> Do you Smoke? |
| <input type="checkbox"/> Previous Falls | |

What are your goals and/or expectations?

HIPAA NOTICE FOR PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The goal of HIPAA is to understand what is in your medical records and how your health information is used helps you as the patient ensure the accuracy, make more informed decisions when authorizing disclosure to others and better understand who, what, where and why others may access your health your health information.

We at Alpine Sports Medicine are required to maintain the privacy of your health information and notify you that we have complied with the legal duties and privacy practices with respect to your information. If our information practices change, we will notify you of any changes.

Signature _____ Date / / _____