



Account # _____

Office _____

Initial Contact ____/____/____

Initial Eval Date ____/____/____

PLEASE COMPLETE ENTIRE TOP BOX

Patient Name (Last) _____ **(First)** _____ **(MI)** _____ **email address** _____

Address _____ **City** _____ **State** _____ **Zip** _____ **Home Phone(____)** _____

\$\$\$# _____ **Sex** M F **Birthdate** ____/____/____ **Marital Status** _____ **Work Phone (____)** _____

Employer _____ **Address** _____ **Cell Phone(____)** _____

Insurance Holder Name(Last) _____ **(First)** _____ **(MI)** _____ **Holder Birthdate** ____/____/____

Insurance Holder Address _____ **City/State/Zip** _____ **Home Phone(____)** _____

Insurance Holder Employer _____ **Work Phone(____)** _____ **Relationship to Patient** _____

Insurance Holder \$\$\$# _____ **Emergency Contact** _____ **Phone(____)** _____

Symptom Onset or Surgery Date ____/____/____ **Is this due to:** Work Auto Other None **Body Part:** _____

Name of Referring M.D. _____ **Address** _____ **Phone(____)** _____

Primary Insurance _____ **Phone (____)** _____ **Fax (____)** _____

Ins. Address _____ **City** _____ **State** _____ **Zip** _____ **Phone(____)** _____

ID/Policy/Claim# _____ **Group #** _____ **Effective Date** ____/____/____

If W/C or Auto, Name of Case Manager or Adjuster _____ **Phone(____)** _____ **ext.** _____

Secondary Insurance _____ **Policyholder Name** _____ **D.O.B.** ____/____/____

Ins. Address _____ **City** _____ **State** _____ **Zip** _____ **Phone(____)** _____

ID/Policy/Claim# _____ **Group #** _____ **Effective Date** ____/____/____

*****For Office Use Only*****

Diagnosis Codes _____ **Therapist Code** _____ **Date of Rx** ____/____/____

Date of Verif ____/____/____ **Spoke with:** _____ **Deductible \$** _____ **Co-Pay \$** _____ **Co-insurance %** _____

Precert needed? _____ **Referral needed?** _____ **Max visits or Limitations** _____

Authorization # and Number of Visits Approved _____ **Any prior visits?** _____

Secondary Benefits: _____

Authorization and Assignment of Benefits

I hereby authorize Maryland SportsCare & Rehab, LLC to apply for benefits from my insurance carrier(s) listed above and further authorize payment directly to Maryland SportsCare & Rehab, LLC of the medical benefits, if any, otherwise payable to me for services rendered by Maryland SportsCare & Rehab, LLC.

Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Maryland SportsCare & Rehab, LLC for my services furnished to me by Maryland SportsCare & Rehab, LLC. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Maryland SportsCare & Rehab, LLC to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment of _____ (patient). Further, I authorize Maryland SportsCare & Rehab, LLC to disclose complete information concerning records regarding the illness or accident of _____ (patient) to any collateral source in the case of Medicare, the Social Security Administration and the Health Care Financing Administration that will pay part or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information.

I understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Maryland SportsCare & Rehab, LLC reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the event my bill is referred to collection, I agree to pay the pre-judgment interest, reasonable attorney fees, court costs and service of process costs to said physical therapist in addition to the amount owed for the services rendered.

Estimated Portion Due from Patient: _____

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical or occupational therapists and/or physical or occupational therapist assistants associated with Maryland SportsCare & Rehab, LLC.

X _____ (Seal) _____
 Signature of Patient or Guarantor, if Minor Date Witness
 Relationship to Patient _____



Notice of Privacy Practices

In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed.

Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claim or for health care operations, which may include but are not limited to: 1) Receive Payment, 2) Verify Insurance, 3) Conduct Quality Assessment, 4) Care Co-ordination/Management, 5) Manage Our Business, 6) Assist Other Covered Entities With Their Health or Business Operations, 7) Accreditation, Certification, Licensing, or Credentialing, 8) Disclosure to the Secretary of the United States Department of Health & Social Services, 9) Health Oversight Agencies, 10) To prevent a serious threat to Health or Safety, 11) Research, 12) Workman's Compensation, 13) Public Health & Safety, 14) Legal, National Security or Law Enforcement, 15) Personal Physician, Team Physician, Athletic Director or Coach, 16) To you or your Designee upon written request, 17) Other uses and disclosures of PHI only after your written authorization.

All Evaluations, Progress Notes as well as significant changes in Medical Conditions will be reported via Fax, Phone, and or Mail to your Referring Physician and possibly Primary Care Physician. All insurances will be verified with pertinent PHI being released to the Insurance Company(s) necessary to process claims. All patients will be asked to sign in at the Front Desk upon arrival and names will be announced. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign in on the sheet, not to have your name announced, not to bill claims electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to accommodate your needs. If you have any questions, please ask to speak to the Clinical Director.

Thank You,

Patient Signature

Date