Galena Sport Physical Therapy
South:775-384-1400
Sparks:775-507-4084
www.galenasport.com

PATIENT INFORMATION SHEET
PLEASE PRINT CLEARLY

Patient Information		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Date of Birth	How did you hear about us?	Gender Male Female
How would you like to be reminded of your appointment?	Voice Email Text	Occupation
Responsible Party Information (if different than above)		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Date of Birth	Relationship to Patient	Gender Male Female
Emergency Contact 1		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Relationship to Patient		
Emergency Contact 2		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Relationship to Patient		

Authorization of Treatment

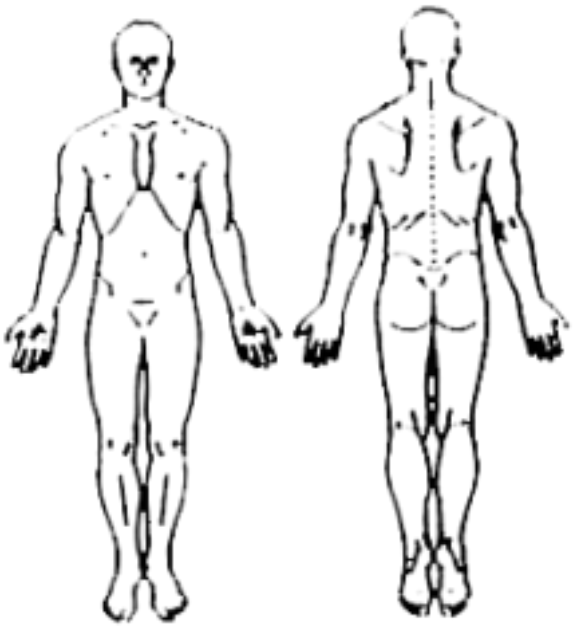
I/We hereby consent to and authorize the performance of physical therapy treatments by the staff of Galena Sport Physical Therapy.

Signature of Patient/Guardian: _____ Date: _____

MEDICAL HISTORY Name:

Current Injury:		
Referring Physician		
Date of Injury (MM/DD/YYYY)	Date of Surgery (MM/DD/YYYY)	If DOI and/or DOS is not applicable, how long has this been a problem?
Is this injury related to work? Yes No	Is this injury related to an auto accident? Yes No	Are you currently in litigation?
Briefly describe your symptoms and the mechanism of onset, if applicable.		

Please indicate on the diagram where your symptoms are located:



Are your symptoms:
□ improving □ staying same □ getting worse

Have you had any testing? □ X ray □ MRI □ CT Scan □ EMG/Nerve Conduction test □Other: _____ Results:
_____

Have you ever had these symptoms before? □ Yes □ No If yes, when? _____

Have you had treatment for this before?
_____

Please rate your pain (0= no pain, 10 =extreme pain)

at worst: 0 1 2 3 4 5 6 7 8 9 10

at best: 0 1 2 3 4 5 6 7 8 9 10

currently: 0 1 2 3 4 5 6 7 8 9 10

Please note up to 3 activities you are unable or have a difficult time performing because of your symptoms and rate on a scale of 0-10 your ability to perform these activities:

Activity	Unable ----------No Difficulty	
1.	0 1 2 3 4 5 6 7 8 9 10	
2.	0 1 2 3 4 5 6 7 8 9 10	
3.	0 1 2 3 4 5 6 7 8 9 10	

Please list your weekly activities:
What are your goals for coming to therapy?

MEDICAL HISTORY (CONTINUED) Name:

Surgical History / Hospitalization (please indicate the year of surgery or hospitalization)
I have no surgical and/or hospitalization history.
1.
2.
3.
Medications (please indicate the dosage)
I am not currently taking any medications
1.
2.
3.
Allergies (drugs, materials, food, animals, etc.)
I have no known allergies
1.
2.
3.

Please indicate if you have ever had, or currently have, any of the following diagnoses:					
Heart Disease		Kidney Disease		Immunosuppression	
Cauda Equina Syndrome		Heart Attack(s)		Seizures	
Stroke		Hepatitis A, B, or C		Hernia	
Current or recent infection		HIV/AIDS		Fibromyalgia	
Cancer		Liver Disease		Chest Pain	
Diabetes—Type 1 or 2		Nervous Disorder		Shortness of Breath	
Asthma		Changes in Sensation		Changes in Vision	
Frequent Heartburn		Dizziness/Fainting		High Cholesterol	
Chronic Headaches		High Blood Pressure		Gastrointestinal Disorders	
Pregnant		Metal Implants		Recent change in weight (either gain or loss)	
Pacemaker		Sensitivity to heat/ice		Smoking (how many packs/day)	
Osteoporosis/osteopenia		Anxiety/Depression		Pain with cough/sneeze	
Osteoarthritis		Rheumatoid Arthritis		Other (please describe):	
Bowel Bladder Changes		Previous Fractures (please indicate):			

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BRINGING CHILDREN TO APPOINTMENTS

Although we understand that you sometimes need to bring your children to your appointment, we ask that they are not disruptive and not left unattended. We want you to be able to focus on your treatment, and we want to keep you, your child, and other patients safe at all times. Thank you!

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF RELEASE INFORMATION

I hereby assign and transfer the entire medical insurance benefits payments, to which I am entitled to Galena Sport Physical Therapy. I understand that any charges that are not covered by the assignment are my sole financial responsibility. I hereby authorize Galena Sport Physical Therapy to release any and all information acquired through my evaluation and treatment. A photocopy of this authorization is accepted as the original.

Signature of Patient/Guardian: Date:

CANCELLATION/NO-SHOW POLICY

Physical Therapy appointments occur 2-3 times per week during your course of treatment. As an organization, we understand that it can often be difficult to make this time commitment. Any number of events can cause the need to cancel or reschedule your appointment. While we understand and appreciate scheduling difficulties, we must have at least a 24-hour notice if an appointment is to be canceled. Given a day's notice, we are in most instances able to re-fill that opening with another patient needing to attend therapy. Without notice, another patient will miss their opportunity for treatment.

If you fail to provide a 24-hour notice of your cancellation or do not show up to your scheduled appointment, you will be assessed a $35 fee. However, if you are able to reschedule the appointment within the same week, you will not be charged. This fee must be collected at the time or before the following visit in order for therapy services to continue. If you are more than 15 minutes late, we may have to cancel the appointment.

Signature of Patient/Guardian: Date:

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STATEMENT OF OFFICE POLICY

As you begin physical therapy treatment here, we hope there is a mutual understanding of the payment for services. We make every effort to obtain a quote for your insurance benefits and relay those figures to you. It is explained to us as we receive this quote that it is an estimate and not a guarantee of payment. It is virtually impossible for any insurance company to quantify payment prior to receiving our claims for services provided. When we quote your benefits, we are simply reiterating those figures given to us by your insurance carrier. There is no guarantee that the quoted percentage obtained by telephone will be the actual benefits paid after receiving our claim.

You are required to inform Galena Sport Physical Therapy of any changes made to your insurance coverage within two weeks of the change being made. These changes include but are not limited to changing your insurance company/ provider and increasing or decreasing your benefits with your current insurance company/ provider. This information is vital because changes to your coverage affect copayment amounts, patient portions, as well as deductibles. As a result of changes, you may be responsible for paying either a higher or reduced amount(s).

In the event of a dispute with an insurance carrier, it is the responsibility of the patient to seek recourse. If the insurance carrier denies payment for services provided, it is ultimately the patient's financial responsibility to see that payment is made. We will make determined efforts to secure proper insurance payment for the treatment you receive, and we will ask that you also contribute your time and energy to facilitate the process.

I HAVE READ AND UNDERSTAND THE STATEMENT OF OFFICE POLICY AS IT IS WRITTEN ON THIS FORM. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL TREATMENT SERVICES RENDERED TO ME.

Signature of Patient/Guardian: _____ Date: _____

CONSENT TO TREATMENT OF MINOR CHILDREN

Patient Name:	
Age:	
Diagnosis:	

I hereby authorize physical therapy services to be provided by Galena Sport Physical Therapy on the child listed above.
I agree to free Galena Sport Physical Therapy and all of its employees of any complaints, lawsuits for damages, or complications which may follow physical therapy treatments.

Signature of Patient/Guardian: _____ Date: _____

GALENA SPORT HIPAA AND PRIVACY PRACTICES

HIPAA

Galena Sport Physical Therapy remains compliant with the HIPAA Privacy Rule effective April 2003 according to the United States Department of Health and Human Services; OCR Privacy Rule (revised 05/03). It restricts the release of any information about any of our patients without the patient's specific authorization.

The Privacy Rule protects all "individually identifiable health information" held or transmitted to us, in any form or media, whether electronic, paper, or verbal to be kept confidential.
"Individually Identifiable Health Information" is information, including demographic data that relates to:

- The individual's past, present, or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual
- And that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

(Some examples would include name, address, birth date, Social Security #, alias names, etc)

The Privacy Rule limits the circumstances in which an individual's protected health information may be used or disclosed. 1) as the Privacy Rule permits or; 2) as the individual patient who authorizes in writing.

A copy of the "Summary of the HIPAA Privacy Rule" is kept at the front desk of all clinics.

NOTICE OF PRIVACY PRACTICES/HIPAA
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Privacy Practices/HIPAA of Galena Sport Physical Therapy. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (775) 384-1400. If you have any questions about our Notice of Privacy Practices, please contact:

Kasey Dunn
16560 Wedge Parkway, Suite 200A
Reno, NV 89511
Phone: (775) 384-1400
Fax: (775) 384-1367
Kaseyd.galenasport@gmail.com

I acknowledge receipt of the Notice of Privacy Practices of Galena Sport Physical Therapy.

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INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Provider Representative: Date: