

PIONEER SPINE AND SPORTS PHYSICIANS – PATIENT REGISTRATION

Last Name: _____ First Name: _____ M.I. _____ DOB: ____/____/____

Age: _____ Soc. Sec. #: _____ - _____ - _____ Sex: M () F ()

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Cellphone: _____ E-Mail: _____

Emergency Contact: _____ Relationship: _____ Phone #: () _____

Employer: _____ Phone#: () _____

Workers Compensation Case ()

M.V.A./Auto Accident ()

Date of Injury: _____

Date of Accident: _____

BILLING INFORMATION

Primary Insurance: _____ I.D. #: _____ Group #: _____

Please fill out the following by placing a check next the correct answer ()

Are You Participating In Physically Handicapped Childrens Program: Yes (), No ()

Student Status: Full Time (), Part Time (), Not A Student ()

Race: American Indian/Alaska Native (), Asian (), Black/African American (),
Native Hawaiian/Other Pacific Islander (), White (), Other (),
Patient Declined/Unknown ()

Ethnicity: Hispanic/Latino (), Not Hispanic/Latino (), Patient Declined/Unknown ()

Patient's Primary Language: English (), Spanish (), Arabic (), Polish (), Portuguese (),
Russian (), Vietnamese (), Patient Declined/Unknown (), None () Other: _____

(Continued On Back)

CONSENT FOR TREATMENT

I authorize PIONEER SPINE & SPORTS PHYSICIANS and/or their designee to examine, treat and perform any diagnostic testing or certain procedures in the office deemed necessary to properly evaluate my condition.

_____ Date: _____/_____/_____
Patient or Empowered Representative

ASSIGNMENT OF BENEFITS

I authorize release of medical information necessary to process any and all claims for services rendered to me by PIONEER SPINE & SPORTS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. I authorize payment of any and all benefits to be made on my behalf to the office of PIONEER SPINE & SPORTS PHYSICIANS. I understand that I am financially responsible for all charges. I have read this information and I understand its contents.

_____ Date _____/_____/_____
Patient or Empowered Representative

MISSED APPOINTMENT POLICY

If you miss an appointment and do not cancel the appointment ahead of time, this may be considered a "no show." Any missed appointment may be subject to a \$20.00 missed appointment fee.

_____ Date _____/_____/_____
Patient or Empowered Representative

Attorney's Name (if applicable)

_____ Address: _____

Phone: _____

Current activity level: _____

Please indicate which activities and how long you are able to perform those activities before having to stop (within the last two weeks)

- | | | |
|-----------------|------------------------------|----------------------------------|
| _____ Standing | _____ Squatting | _____ Lying on Stomach/Back/Side |
| _____ Sitting | _____ Kneeling | _____ Turning in Bed |
| _____ Driving | _____ Reaching Overhead | _____ Writing/Typing |
| _____ Slow Walk | _____ Bending/Lifting | _____ Gripping/Opening Jar |
| _____ Fast Walk | _____ Putting on Socks/Shoes | _____ Turning a Key |
| _____ Running | _____ Up/Down Stairs | _____ Other (Including Sports) |

Is sleep disturbed? Yes ___ No ___ Please Explain: _____

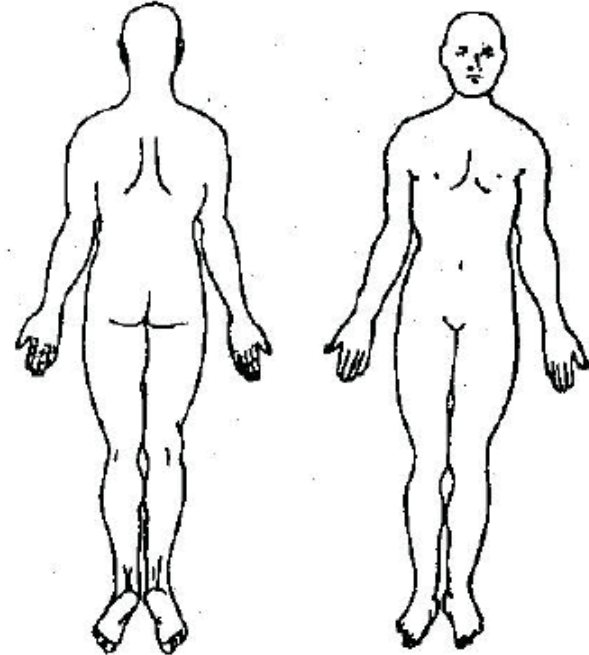
Do you have numbness/tingling/burning? Yes ___ No ___ Where? _____

What brings on pain? _____ What eases pain? _____

Is Pain: Constant? ___ Off and On? ___ Weakness: Yes ___ No ___ Where? _____

Pain Scale: Please circle pain at lowest: 0 1 2 3 4 5 6 7 8 9 10 (Emergency)
Please circle pain at highest: 0 1 2 3 4 5 6 7 8 9 10 (Emergency)

Please shade areas of pain:



Your goals for P.T.: _____

Patient Signature: _____ Date: _____

Phone Number: _____

DETACH THIS PAGE FOR YOUR RECORDS

ATTENTION PATIENTS

Many insurance companies require that referrals and authorizations be in place prior to treatment being rendered.

It is the responsibility of the patient to call their primary care physician for any referrals, or to call their insurance company with any prior notification that is required. If the referral is not in place at the time of your visit, you will be asked to sign a waiver if treatment is rendered.

If your insurance requires authorization after your initial evaluation, you will not be scheduled for any follow-up appointments until we have received authorization for your future visits.

If you have any questions, please feel free to call the Physical Therapy Department.

Thank you,

Pioneer Spine and Sports Physicians

OUTPATIENT SCHEDULING INFORMATION SHEET

- After your initial visit, you will receive a schedule of appointments.
- It is your responsibility to participate and attend all scheduled appointments.
- If you are unable to attend an appointment you **MUST** notify PSSP Physical Therapy at (413) 785 – 5777. We urge you to call **24 HOURS** prior to your scheduled appointment if you would like to cancel. The secretary will either reschedule or confirm your next appointment.
- If you are more than 15 minutes late for your appointment, the attending therapist reserves the right to cancel your appointment if he/she deems necessary.
- If you miss an appointment and do not cancel the appointment ahead of time, this will be considered a “**no-show**”. You will be subject to a \$20.00 missed appointment fee.
- If you “**no-show**” for two consecutive appointments, you will be discharged.
- If you “**no-show**” for a total of three appointments, you will be discharged.
- If you **cancel** for a total of four appointments, you will be discharged.
- When you are discharged under the above conditions, the following will be notified in writing:
Your physician
Your insurance company
Your attorney
Your workman’s compensation carrier
All other parties involved.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I UNDERSTAND THAT THE PURPOSE OF REGULAR ATTENDANCE WILL ALLOW ME TO GAIN MAXIMUM BENEFIT FROM THERAPEUTIC INTERVENTION.

PATIENT SIGNATURE: _____ DATE: _____

PIONEER SPINE AND SPORTS PHYSICIANS, P.C.

HIPAA CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Pioneer Spine and Sports Physicians (PSSP) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Pioneer Spine and Sports Physicians (PSSP). I understand that diagnosis or treatment of me by Pioneer Spine and Sports Physicians (PSSP) may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations is not required to agree to the restrictions that I may request. However, if Pioneer Spine and Sports Physicians (PSSP) agrees to a restriction that I request, the restriction is binding on Pioneer Spine and Sports Physicians (PSSP) and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pioneer Spine and Sports Physicians (PSSP) has taken action in reliance on this consent.

My “protected health information” means health information including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Pioneer Spine and Sports Physicians’ Notice of Privacy Practices prior to signing this document. The Pioneer Spine and Sports Physicians’ Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Pioneer Spine and Sports Physicians. The Notice of Privacy Practices (PSSP) is also provided in waiting rooms. This Notice of Privacy also describes my rights and the Pioneer Spine and Sports Physicians’ duties with respect to my protected health information.

Pioneer Spine and Sports Physicians (PSSP) reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Pioneer Spine and Sports Physicians’ office.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority