PATIENT INFORMATION (CONFIDENTIAL)

REFERRING PHYSICIAN_______________________

NAME____BIRTHDATE______/_______/_______
FIRST MI LAST

ADDRESS____CITY_____________STATE_______ZIP___________

EMAIL____ CELL PHONE (_____)_____________

REFERRED BY: ☐ DR.__________________ ☐ FAMILY/FRIEND_______________ ☐ OTHER__________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME _____________________________RELATIONSHIP__________________PHONE #___________________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _________________________ RELATIONSHIP_______________

ADDRESS ____HOME/CELL PHONE # ________________

DRIVERS LICENSE #______________________BIRTHDATE_____/_____/_______SS#_____________________________

EMPLOYER ____ WORK PHONE#________________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

INDICATE PRIMARY INSURANCE: ☐ BCBS ☐ CIGNA ☐ LIBERTY HEALTH SHARE ☐ HUMANA

☐ SCOTT & WHITE HP ☐ UNITEDHEALTH CARE ☐ OTHER/ SELF PAY ___________

INSURANCE ID # __________________________ GRP # _________________ INSURANCE TEL # _____________________

INSURANCE CO ADDRESS _________________________________CITY _______________ STATE_______ZIP___________

POLICY HOLDER NAME ____ RELATIONSHIP ________________________

BIRTHDATE_______/_______/_______ SS#_____________________ EMPLOYER _______________________________

EMPLOYER ADDRESS____ WORK PHONE #________________________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

INSURANCE CO________________ ID #_________________ GRP #____________________

POLICY HOLDER NAME______________________BIRTHDATE________________ RELATIONSHIP____________________

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE MONDO SPORTS THERAPY OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS

PATIENT/ GUARDIAN SIGNATURE _______________________________________ DATE ________________________

Health History Form

Please check YES or NO:

Have you or any immediate family member ever been told you have:

	Yourself YES	Yourself NO	Family YES	Family NO
Cancer?	☐	☐	☐	☐
High blood pressure?	☐	☐	☐	☐
Heart disease?	☐	☐	☐	☐
Angina/chest pain?	☐	☐	☐	☐
Stroke or TIA?	☐	☐	☐	☐
Osteoporosis?	☐	☐	☐	☐
Osteoarthritis?	☐	☐	☐	☐
Rheumatoid arthritis?	☐	☐	☐	☐
Head/Neck Trauma?	☐	☐		

In the past 3 months have you had or do you experience:

	YES	NO
A change in your health?	☐	☐
Nausea/Vomiting?	☐	☐
Fever/chills/sweats?	☐	☐
Unexplained weight loss?	☐	☐
Numbness or tingling?	☐	☐
Changes in appetite?	☐	☐
Difficulty swallowing?	☐	☐
Bowel or bladder issues?	☐	☐
Shortness of breath?	☐	☐
Dizziness?	☐	☐
Upper respiratory infection?	☐	☐
Urinary tract infection?	☐	☐

Have you previously had any trauma to your head and neck? (i.e. blunt trauma, fall, ejection from car, serious car accident, concussion etc.) ☐ ☐

If YES, please briefly describe:

____

____

If YES, have you had head or neck imaging performed since the event? ☐ ☐

Name:______________________________________

Age: _______

Please provide an email address where we can send you your physical therapy exercises:

____

Please check YES or NO:

Do you have a history of:

	YES	NO
Allergies/Asthma?	☐	☐
Headaches?	☐	☐
Autoimmune disease?	☐	☐
Rheumatoid disease?	☐	☐
Blood-borne disease?	☐	☐

	YES	NO
Are you currently pregnant?	☐	☐

Are your current symptoms: (check one)

☐ Getting better ☐ The same ☐ Getting worse

How are you able to sleep at night? (check one)

☐ No difficulty ☐ Some difficulty ☐ Extreme difficul

Do you have a problem with ... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you smoked tobacco?

YES NO

If yes, how many packs/day/week and for how many years did you smoke?________________

Last tobacco use? _____________

Date of last physical exam:__________________

Please list medications, vitamins or supplements you are currently using (this is important to us because some medications and supplements effect tissue healing):

____

____

____
____
____

Please describe the issue that you are coming in for today. If you have undergone a surgery for this body part, please write down the surgery that was performed, the date it was performed and the name of the physician that performed the surgery:

____
____
____
____
____
____

When did your symptoms start?

____
____

Have you previously received treatment for the condition we are seeing you for today? If so, what treatment have you received and did it help?

____
____
____

Do you have any other medical conditions that we should be aware of before initiating physical therapy treatment? If so, please describe.

____
____

Do you consent to having dry needling performed as part of your treatment? (dry needling is only performed if your clinician thinks it will assist in your rehabilitation process and, of course, is not mandatory).

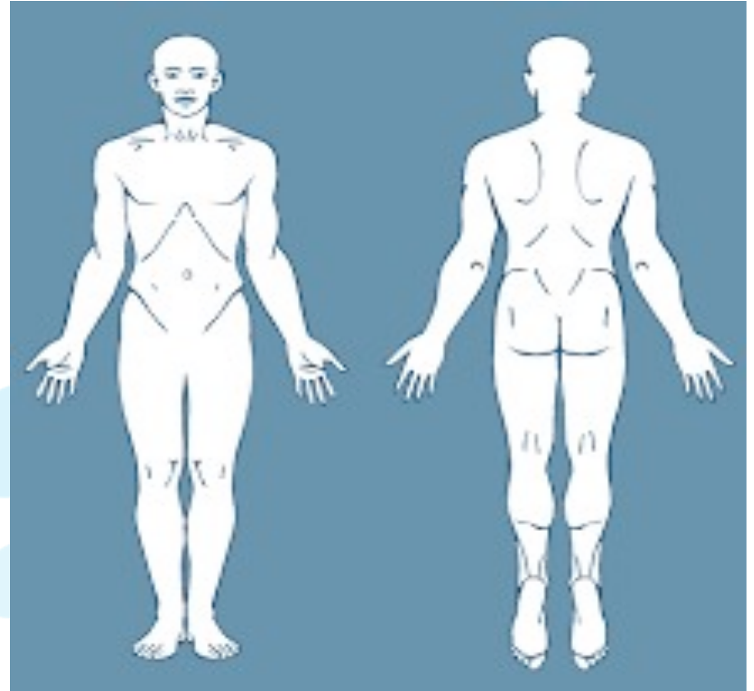
Yes No Maybe (I want more info)

Please verify that all of the information provided is accurate to the best of your knowledge and that you consent to treatment by Mondo Sports Therapy for this condition.

Patient signature (adult if minor):

____

Please mark your area(s) of pain on the diagram below:



For the following items, please use a 10-point scale with 0 being no pain and 10 being pain that requires you to go to the emergency room:
If this is not applicable to your symptoms, please disregard this section.
What is your pain at its worst? _______
What is your pain at its best? ________

PLEASE USE THE ADDITIONAL SPACE ON THIS FORM TO LIST ANY FURTHER QUESTIONS, CONCERNS OR MEDICAL CONDITIONS THAT WE SHOULD BE AWARE OF PRIOR TO TREATMENT. Thank you, Mondo Sports Therapy.

Patient Rights & Responsibilities

As a patient, you have the right:

- To have your privacy protected and to receive our Notice of Privacy Practices.
- To look at or get copies of your medical information. If you request copies, there will be an associated fee for compiling and printing the documents. Contact the front desk for more information.
- To have information about your diagnosis, choices, risks and benefits of treatment so you can assist in developing your plan of care, including management of pain.
- To have a family member or representative and your physician notified promptly of admission to the hospital.

As a patient, you have the responsibility:

- To give your physical therapist correct and complete information about your present medical condition, past illnesses, hospitalizations, medications, including over the counter drugs/herbal supplements and other health matters.
- To tell your physical therapist that you understand the plan of treatment and what is expected of you and ask questions if you do not understand.
- To follow the treatment plan recommended by your physical therapist
- To keep scheduled appointments or **give 24-hour notice** if you cannot make your scheduled appointment time.
- To accept responsibility for your actions if you refuse treatment or do not follow the physical therapist's instructions.
- To meet your health care financial obligations.

Patient Payment Policy

How may I pay?

- We accept payment by cash, check and or Visa, Mastercard, Discover and American Express

Self -pay/Private pay patients:

- Payment is required in full at the time of service. Our out of pocket rate is $120 for the initial evaluation and $95 per follow-up.

PPO/HMO/Commercial Plans:

- We will file your claims to your insurance. **Copays, co-insurances and deductibles are due at the time of service**.
- **Please be aware of your coverage benefits for physical therapy. It is your responsibility to be informed and to comply with the financial obligations your insurance imposes. A benefits quote is not a guarantee of payment; it may be subject to other plan limitations or exclusions.**
- **HMO plans require an authorization from your PCP. It is your responsibility to contact your PCP's referral coordinator to obtain an authorization prior to your appointment.**

Cancellations/No shows:

- 24-hour notice is required for any cancellation or rescheduling of an appointment. The fee for any missed appointment is $50 and will be charged prior to rescheduling.
- Saturday appointment no-shows will incur a full charge of $145 for an evaluation and $95 for a follow up.

I have read and understand the Payment Policy and my Rights and Responsibilities as a patient.

Patient/ Guardian Signature______________________________ Date ________________________

Insurance

Please initial each paragraph to acknowledge that you are aware of our policies:

____Today's reimbursement climate is in a constant state of flux which makes it challenging for our billing department to understand the details of each individual's physical therapy coverage. We do our absolute best to verify and clarify each patient's insurance plan but it is ultimately the policy holder's responsibility to fully understand all the details of their particular plan.

___Office co-pays are due at the time of service. The co-pay amount on your insurance card may not be the co-pay amount for physical therapy visits. You must obtain this information from your customer service representative.

___Your deductible must be satisfied before the insurance company will cover treatment costs. You will be billed for any unsatisfied deductible amount.

___At the time of verifying your insurance, the representative of your insurance plan typically provides us with an estimate of the cost of services that will be covered. However, actual charges may vary from the estimated amount once charges have been entered into the insurer's system. Payments received for services at Mondo Sports Therapy are non-refundable. Any amounts received by Mondo Sports Therapy that are not applied to services within thirteen months of receipt will be forfeited to Mondo Sports Therapy. Patients will be informed of any balance on their account following each visit or by mail if the account has been inactive for 3 or more months.

____If your policy requires a prescription from your primary care physician (PCP) or non-physician practitioner (NPP), you must obtain a current prescription in order for your insurance plan to pay for physical therapy services. The State of Texas requires that you have a current prescription in order to receive physical therapy care.

___If your policy requires a referral or pre-authorization on file, you will need to contact your PCP's referral coordinator and ask that a current copy be sent to both your insurance company and to our office.

___Please be aware that prescriptions, referrals and pre-authorizations have expiration dates and/or a set visit limit. We will assist you in tracking expirations of prescriptions, referrals or pre-authorizations once you have initiated your episode of care.

____Certain rehabilitation benefits may include occupational therapy, speech therapy, massage therapy, or acupuncture. In addition, physical therapy and chiropractic care may also be paid out of the same benefit limit. Please keep in mind that Mondo Sports Therapy can only track your plan and prescription limits for services provided at Mondo Sports Therapy. It is your responsibility to track services received from other practitioners in other offices. If you exceed your plan limits, you are responsible for payment of physical therapy services not covered by your plan.

Patient/Guardian Signature:____Date: ________________

Cancellation Policy

At Mondo Sports Therapy, every appointment scheduled has a specific time allotted on our therapists' schedule. If our patients' no-show or cancel without giving 24-hour notice, we do not have adequate time needed to fill their schedule with another appointment. Please keep this in mind should you need to change or cancel an appointment.

24-hour notice is required for any cancellation or rescheduling of an appointment. The fee for any missed appointment is $50 and will be charged prior to reschedule.

- Any patient with three or more no-shows or cancellations within the same year will be required to prepay $50 to hold any future appointments. The $50 holding fee will be credited to that treatment or forfeited should you not make the appointment.
- **For Saturday appointments**, a no-show or late cancellation will incur a full charge of $145 for an evaluation and $95 for a follow up appointment. Credit cards are required to hold a Saturday appointment.

You can call us at 512-358-1400 or email us at office@mondosportstherapy.com

Thank you for your loyalty, we value you as a patient and appreciate you valuing our time as well.

I hereby acknowledge that I received and reviewed the above cancellation policy and asked questions prior to signing:_____(initial)

Signed:_________________________________ Date:________________________

The information provided on this sheet is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to Mondo Sports Therapy. I also authorize Mondo Sports Therapy to release any information required to process my insurance claims.

PT Benefits Provided by Your Insurance Company

I understand that I am ultimately responsible for any copay, deductible and/or co-insurance. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I understand and agree that I will be financially responsible for any cost, share or balance due that Mondo Sports Therapy is unable to collect from my insurance and that I have the right and responsibility to follow up with my insurance for specific questions regarding my individual policy.

No show/ Late Cancellation

I am aware of the no show/ late cancellation policy and understand and agree that a fee of $50 will be charged to my account or $145/ $95 if my appointment is scheduled on a Saturday, should I be unable to comply with this policy. I further understand that this fee is not covered by my insurance carrier.

Privacy Notice

I acknowledge that I have read and fully understand Mondo Sports Therapy Policies. By signing this form, I am acknowledging my understanding of the “Notice of Privacy Practices” and I have been provided an opportunity to review it and understand my rights as stated therein.

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Patient Name (please print)____________________________ Date of Birth _____________

Patient or Guardian Signature_________________________________ Date _________________