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Patient Information
Assignment of Benefits
HIPPA Practice Notice
Financial Agreement

DEMOGRAPHICS

Full Name: _____

Mailing Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ May we contact you at work: _____(Yes/No)

Email: _____ Age: _____ Birthdate: _____

Marital Status: Single Married Widowed Separated Divorce

Emergency Contact Name _____ **and Phone Number:** _____

Work Status: Disabled _____% Retired Student Employed Unemployed

Employer Name: _____ Phone: _____

Occupation: _____ Family MD: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Policy Holder's Name: _____ Policy Holder's Birthdate: _____

Group Number: _____ ID Number: _____

Patient's relationship to policy holder: Child Spouse Other: _____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct the above listed insurance company to pay by check made out and mailed to: Architech Sports and Physical Therapy/8918 Blakeney Professional Dr., Suite 120/Charlotte, NC 28277.

If my current policy prohibits direct payment to provider, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under the current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional serivce charges over and above this insurance payment. By signing below, I attest to the following: 1) A photocopy of the Assignment shall be considered as effective and valid as the original. 2) I authorize

release of any information pertinent to my case to any insurance company, adjuster or attorney invoiced in the case for the purpose of processing claims and securing payment of benefits. 3) I authorize the use of this signature on all insurance submissions. 4) I authorized ARCHITECH SPORTS AND PHYSICAL THERAPY, INC (hereafter known as ASPT, INC.) to deposit the checks made in my name. 5) I understand that I am financially responsible for all charges whether or not paid by insurance (Please refer to the financial agreement that is posted at the front window and/or on the clipboard (copy available upon request).

NOTICE OF INFORMATION PRACTICE

I have read and fully understood ASPT, INC. Notice of Informaton Practice (copy available upon request). I understand that ASPT, INC. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I hereby consent to the use and disclosure of my personal health information for purposes as noted in ASPT. INC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

DESIGNATED INDIVIDUALS AUTHORIZATION:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I acknowledge and agree to ASSIGNMENT OF BENEFITS, NOTICE OF INFORMATION PRACTICE (posted), FINANCIAL AGREEMENT (posted).

_____ _____

Patient's Signature (or guardian if under 18) Date

_____ _____

Witness Date

8918 Blakeney Professional Dr.
Charlotte, NC 28277
Phone: 704-900-8960
Fax: 704-817-9523

13333 Dorman Rd
Pineville, NC 28134
Phone: 704-716-1024
Fax: 704-716-1025

1001 Van Buren Ave., Suite 3
Indian Trail, NC 28079
Phone: 704-628-6053
Fax: 704-628-6702

Athletic Training Center
Morrison Family YMCA
9405 Bryant Farms Rd
Phone: 704-773-5091
Fax: 704-817-9523

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STATEMENT OF FINANCIAL RESPONSIBILITY

PATIENT NAME:_____ DATE:_____

Architech Sports and Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitation needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure paying in full of your fees. *As a courtesy, we will verify your insurance coverage and bill your insurance carrier on your behalf.* However, you are ultimately responsible for your bill.

You are responsible for payment of any co-payment at the time of service, and upon receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or you or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks and most major credit cards.

I have read the above policy regarding my financial responsibility to Architech Sports and Physical Therapy for providing services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Architech Sports and Physical Therapy. I agree to pay Architech Sports and Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

SIGNATURE:_____ DATE:_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Architech Sports and Physical Therapy through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered medically necessary and proper in diagnosing or treating my/his/her physical condition.

SIGNATURE:_____ DATE:_____

I further authorize Architech Sports and Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patients examination and treatment necessary to secure payment for services provided.

SIGNATURE:_____ DATE:_____

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CURRENT & PMHX/CONSENT TO TREAT

Patient Name: _____ Date: _____

Who referred you to Physical Therapy? _____

Describe your problem: _____

_____

When did your problem begin (approximate date)? _____

Is it getting: _____ Worse _____ Better _____ Staying the Same

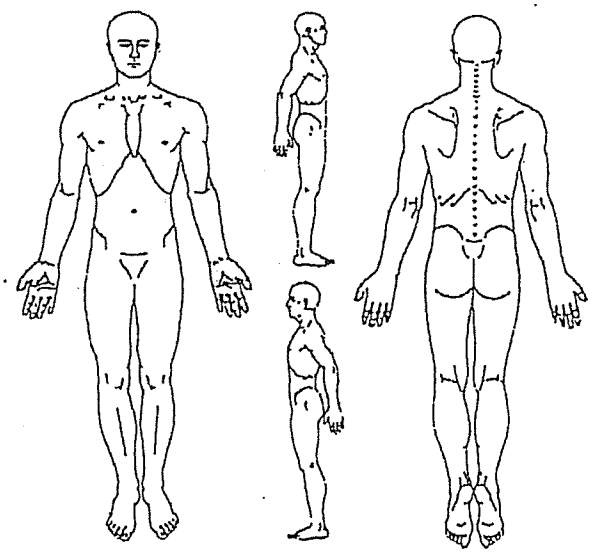
Is your pain constant? _____ Yes _____ No

On a scale from 0 – 10, circle your worst level of pain over the last week?

Mild Moderate Severe

0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 10

On the diagram below, please indicate where you are having pain right now. Use the following key to describe your pain: X = Sharp; D = Dull; T = Throbbing; B = Burning; S = Stabbing; N = Numb



What are your goals for Physical Therapy?

_____

_____

Have you had Physical Therapy for this or any condition in the past? _____ Yes _____ No

Are you currently (or have you received in the past two (2) weeks) Home Health Services of Physical Therapy or Nursing? _____ Yes _____ No

Please list ALL current medications (both prescription and non prescription).	Please list ALL previous surgeries (include dates).

Please list any allergies to medications or to foods: _____

_____

Please circle all that apply: Allergies Anemia Angina (chest pain) Anxiety Asthma Bipolar Disorder Bronchitis Cancer Cirrhosis Depression Diabetes Epilepsy Emotional Problems Emphysema Gallbladder Gout Heart Attack Hepatitis Hiatal Hernia High Blood Pressure HIV Hypoglycemia Kidney Disease Osteoarthritis Osteroporosis Pacemaker Polio Seizures Smoking Stroke Weight Loss Whiplash
Other: _____

Is it possible that you are pregnant? _____Yes _____No

Consent to Treatment: I consent to receive care and/or treatment from ARCHITECH SPORTS AND PHYSICAL THERAPY, INC. I hereby certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient Signature (or guardian if under 18) Date

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