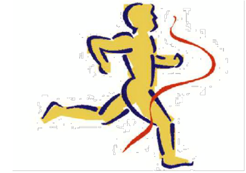
Frederick Sport and Spine Clinics



Sports Physical Therapy and Spine Rehabilitation

PATIENT INFORMATION

Patient's Full Name:		Nickname:
Birth Date: / /	Age:	Sex: ☐ F ☐ M
Street Address *(a P.O. Box is not acceptable)*:		
City/State:		Zip Code:
Social Security Number: - -		
Driver's License Number:		
Home Tel. #: ( )	Cell # ( )	
Work #: ( )	Which do you prefer we use to contact you directly? **H** ☐ **C** ☐ **W** ☐	
Email Address *(for in-house use **only**)*:		
Guarantor's Full Name *(if different from patient)*:		
Guarantor's Birth Date: / /		
Guarantor's Social Security Number: - -		
Guarantor's Street Address:		
Guarantor's Tel. #: ( )		
Spouse's Full Name:		
Spouse's Birth Date: / /		
Spouse's Employer and Address:		
Spouse's Work Tel. #: ( )		
Emergency Contact Name:		Tel. #: ( )
Patient's Employer:		Position Title:
Employer Address:		
City/State:		Zip:

INSURANCE INFORMATION

Do you have Insurance?	
Primary Insurance Carrier:	
Name of Subscriber:	DOB:
Policy #:	Group#:
Employer:	

For office use only: *demographics completed: in Mastermind: _____, Mastermind #: ______________________
*demographics completed in WebPT: _____
*Physician info is correct in systems: _____

initials: ____

Are your symptoms a result of an occurrence at work? ☐ Y ☐ N
Are your symptoms a result of an automotive incident? ☐ Y ☐ N
If you have answered **yes** to either question above, please indicate the date of occurrence:

REFERRING DOCTOR INFORMATION

Name of the Referring Doctor:
Address of Referring Doctor:
Tel. #: ( )
Your Primary Care Doctor ***(if different from Referring Doctor)***:
Address of your Primary Care Doctor:
Tel. #: ( )

Date symptoms began: / / Describe how your symptoms began:

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Frederick Sport and Spine Clinic, Inc., for services rendered by Frederick Sport and Spine Clinic, Inc. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Frederick Sport and Spine Clinic, Inc., as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. **Additionally, I specifically authorize Frederick Sport and Spine Clinic to release information from my medical record to; __________________________. (i.e. Spouse, Parent, Guardian, other).**

I understand that my account balance is due in full upon receipt of my billing statement. If my account becomes assigned to a collection agency, I agree to pay 25 percent collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent interest per month on the unpaid balance. All co-pays are due at the time of service. If we must send you a billing statement, a $25.00 *per statement* billing fee will be assessed.

SIGNATURE (Patient): ________________________________ DATE: ________________

SIGNATURE (Guarantor): _____________________________ DATE: ________________