Kimberly J. Bozart-Dow, PT, A Professional Corporation

PATIENT INFORMATION Today's Date: ____/______/______

Name: ____ SS#_______/_______/________
First MI Last

◯ Male ◯ Female Date of Birth: _____/_____/_______ Occupation: ______________________

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Spouse/Partner Name: ____ Phone: (_____) ______-_______

Address: ____
Street Address City State Zip Code

Home Phone: (_____) ______-_______ Email Address: ____

Would you like to receive reminders by email? ◯ Yes ◯ No

Cell Phone: (_____) ______-_______Would you like to receive reminders via text message? ◯ Yes ◯ No

Emergency Contact: __________________________________ Relationship: ___________________

Ph: (____) ______-___________

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Accelerated Sports Physical Therapy.

Signature: ____ Date: _____/______/______
(Parent or legal guardian must sign if patient is under 18 years of age)

Relationship: _________________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand ASPT reserves the right to modify the privacy practices outlined in the notice and I have received or been offered a copy of the Notice of Privacy Practices for ASPT. (circle one): Received / Offered

Signature: ____ Date: _____/______/______
(Parent or legal guardian must sign if patient is under 18 years of age)

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CONCIERGE AGREEMENT

I, ____ have chosen to be treated as a Concierge/Cash Pay patient for Physical Therapy services provided at Accelerated Sports Physical Therapy (ASPT).

I understand and agree that I am responsible for all the charges regardless of my existing medical insurance coverage. I will be required to pay for each visit **on the day services are rendered**. I agree to make this payment in the form of cash (US dollars), or credit card (Visa, MasterCard, American Express or Discover).

I agree to pay (please check ✅ one or more):

_____ $300.00 Initial Evaluation and $250.00 per follow-up visit(s)(Business Hours M-F).

_____ $350.00 Initial Evaluation and $300.00 per follow-up visit(s)(Weekend /After Hours).

_____ $550.00 Initial Evaluation and $500.00 per follow-up visit(s) (Las Vegas Strip Business Hours M-F).

_____ $600.00 Initial Evaluation and $550.00 per follow-up visit(s) (Las Vegas Strip Weekend/After Hours).

_____ $____* as determined by Owner

I further understand that in choosing this method of payment, Accelerated Sports Physical Therapy (ASPT) will **not** be billing or contacting any third party for my services (such as private insurance, auto insurance, auto lien, attorney lien, etc.) and that ASPT will **not** go back at a later date to bill a third party for any services that have already been provided in relation with this current episode of care.

I understand and agree, that I will be responsible for contacting any third party (such as private insurance, auto insurance, auto lien, attorney lien, etc.), in the event that I chose to seek reimbursement and/or apply amounts paid to my insurances deductible for physical therapy services provided. I understand ASPT recommends patients contact any third party (such as private insurance, auto insurance, auto lien, attorney lien, etc.) to confirm reimbursement policies. I understand ASPT will provide receipt(s) upon payment for dates of service(s).

I understand and agree that if it becomes necessary for ASPT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $50 processing fee), in addition to, attorney fees, court costs and other expenses of litigation.

Signature: ____ Date:_____/______/______
(Parent or legal guardian must sign if patient is under 18 years of age)

Print Patient Name: ____

* Owner Signature: ____

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MEDICAL HISTORY

Existing or Relevant Previous Conditions

Condition		Condition		Condition	
Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

HEIGHT: _________ WEIGHT: _________

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

FALL HISTORY

☐ Injury as a result of a fall in the past year? Date of injury or onset: ________________

☐ Two or more falls in the last year?

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INJURY DESCRIPTION

Date of Surgery: _____/______/______ Date of Injury: _____/______/______

Describe your injury :

SURGICAL HISTORY

Date:_____/______/______ Surgery: ____________________________

Surgeon: ____________________________

Date:_____/______/______ Surgery: ____________________________

Surgeon: ____________________________

Date:_____/______/______ Surgery: ____________________________

Surgeon: ____________________________

PLEASE ADD ADDITIONAL SURGERIES ON BACK OF PAGE.

CURRENT MEDICATIONS

Drug: ____________________ Dosage: ________ Frequency: __________

Reason Taking: _____________________________

Drug: ____________________ Dosage: ________ Frequency: __________

Reason Taking: _____________________________

Drug: ____________________ Dosage: ________ Frequency: __________

Reason Taking: _____________________________

PLEASE ADD ADDITIONAL MEDICATIONS ON BACK OF PAGE.

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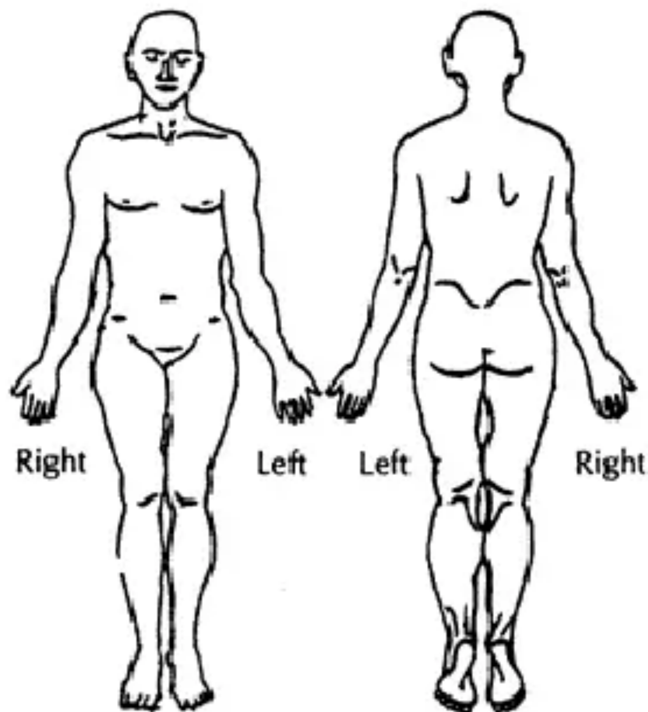
Name: ______________________

Date: ______________________

Pain Chart

Using the symbols below, mark on the body the areas where you feel that particular sensation.

Numbness	Pins & Needles	Burning	Aching	Sharp/Stabbing
//////	+++++	00000	XXXXX	*******



PLEASE CIRCLE YOUR LEVEL OF PAIN: (1 = Minimal Pain; 10= Worst Pain Imaginable)
PAIN CURRENTLY 1 2 3 4 5 6 7 8 9 10
PAIN AT ITS WORST 1 2 3 4 5 6 7 8 9 10
PAIN TYPICALLY 1 2 3 4 5 6 7 8 9 10