



Personal Information

Name: _____ Social Security Number: _____
Sex: M/F: _____ Age _____ Date of Birth _____
Mailing Address _____ City _____ State _____ Zip Code: _____
Home Phone # _____ Cell #: _____ Work Phone#: _____
Employer: _____ Occupation: _____
Marital Status: S / M / D / W Email: _____

Insurance Information

Primary Insurance Co. Name: _____ Type: Medical/Auto/Other
Company Address _____ City _____ State _____ Zip Code: _____
ID # _____ Group#: _____ Claim#: _____
Subscriber Name: _____ Subscriber D.O.B: _____
Subscriber Social Security #: _____ Relation to Subscriber: _____
Coverage Effective Date: _____ Date of Injury: _____

Secondary Insurance Co. Name: _____ ID#: _____
Group#: _____ Coverage Effective Date: _____
Company Address _____ City _____ State _____ Zip Code: _____
Subscriber Name: _____ Subscriber D.O.B: _____
Subscriber Social Security #: _____ Relation to Subscriber: _____

In Case of Emergency Notify:

Name: _____ Phone Number: _____

How were you referred to Our Office?

Newspaper/Magazine: _____ Family/Friend: _____

Internet: _____ Physician: _____

Other: _____

Patient Medical History

Patient Name: _____

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for Today's Visit: _____

Describe your symptoms _____

Rate your Pain (0= no pain, 10= worst imaginable pain) _____

When and how did it start? _____

What makes it better? _____ Worse? _____

Have you been treated for this condition in the past?YES / NO (If Yes, what treatments have you had?)

Do you have any questions/ concerns about being treated?

List all Current Medications and Dosages:

Past Medical History

Diabetes	High Blood Pressure	Coronary Artery Disease	Vascular Disease
Heart Disease/Attacks	Congestive Heart Failure	Thyroid Disease	Depression
Lyme Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Asthma	COPD
Cancer	Scoliosis	Stroke	Kidney Disease

Please List any Medical Conditions you may have that is not mentioned above: _____

Family Medical History

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
Heart Disease/ Attacks	Seizures	Strokes	Lung Disease
Rheumatoid Arthritis	Asthma	Scoliosis	Multiple Sclerosis

Please List any Medical Conditions your family may have had that is not mentioned above: _____

Past Surgical History

Surgery	Date	Surgery	Date
Knee Arthroscopy (R/ L)		Shoulder Arthroscopy (R/ L)	
Spine Surgery (cervical/thoracic/lumbar)		Joint Replacement Surgery	
Hernia Repair		Hysterectomy	
Eye Surgery		Cardiac Catheterization	
Peripheral Bypass Surgery		Coronary Artery Bypass Graft	

Please List any other surgery you may have had that is not mentioned above: _____

Do you smoke? Current Smoker Former Smoker Never Smoked Pipe Smoker Cigar Smoker
 If yes, how much do you smoke? 3 cigarettes or less/day 1/2 pack/day More than a pack/day

Do you drink alcohol? YES NO
 If yes, how frequent? social only Several times per week Everyday

Do you or have you used illicit drugs? YES NO
 If yes, what kind? IV Drugs Pills Marijuana Other: _____

Sports Participation: YES NO
 If yes, what sports? Golf Tennis Football Soccer Baseball Basketball Running
 List any other sports you play: _____

Please Circle any of the following symptoms that you have experienced lately:

Constitutional	Fever	Night Sweats	Weight Loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pains	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomitting	Diarrhea
Genitourinary	Burning w/ urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/ Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/ Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have had related to the problems circled above:

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____



PRIVACY NOTICE

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services

Our Uses and Disclosures

Thrive Spine and Sports Rehab, LLC may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

The undersigned has read this notice and has received a copy of this signed notice and the Notice of Privacy Practices, if requested.

Name _____

Signature _____ Date _____



Financial Policy Agreement/ Assignment of Benefits

Thank you for choosing Thrive Spine and Sports Rehab, LLC as your healthcare provider. We are always striving to provide optimal care to all of our patients and we will always do everything we can to achieve this goal.

Thrive Spine and Sports Rehab, LLC is a private professional entity that is *not* contracted with any insurance plans with the exception of Medicare. Even though we are not a participating provider in your insurance plan’s network, we pledge to help you understand and manage the financial aspects associated with providing you the best care possible.

Most insurance plans allow patients to select their own treating physician even if that physician is not contracted with their insurance plan’s network. To help you understand your responsibilities, we will contact your insurance to gather information regarding your out-of-network coverage, and explain what financial obligations you will have for our services.

Due to the fact that we are an out-of-network facility your treatment plan will not be limited by what an insurance company plan representative will approve, but it will be determined by the recommendations made by one of our board certified practitioners with the sole intent of improving your way of life.

All charges will be submitted to your insurance company on your behalf as an out-of-network provider. You may be responsible for your deductible and co-insurance on allowed payments up to your out-of-pocket maximum according to your plan’s out-of-network plan’s coverage. Most insurance plans allow reasonable and customary payment for services rendered at Thrive Spine and Sports Rehab, LLC, in which case you will not receive any bills. In a few cases, however, your plan may not provide reasonable and customary payment for services rendered, and in that case you may be responsible for some of the difference between what is billed and what your insurance plan allows for payment.

In addition some insurance companies may send payment for services directly to you. You agree to relinquish all payments that you receive from your insurance company for services rendered at Thrive Spine and Sports Rehab, LLC. Failure to do so will result in legal action.

By signing below, you attest that you completely understand and agree with our financial policy as described above for all services provided by Thrive Spine and Sports Rehab, LLC.

Assignment of Benefits

Patient Name: _____

I irrevocably assign to THRIVE SPINE AND SPORTS REHAB, LLC all my rights and benefits under any insurance contracts for payment for services rendered to me by THRIVE SPINE AND SPORTS REHAB, LLC. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by THRIVE SPINE AND SPORTS REHAB, LLC to be released to THRIVE SPINE AND SPORTS REHAB, LLC. I irrevocably authorize THRIVE SPINE AND SPORTS REHAB, LLC to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to THRIVE SPINE AND SPORTS REHAB, LLC. I irrevocably authorize THRIVE SPINE AND SPORTS REHAB, LLC, to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X _____

Patient Signature

Patient Name (printed)

Date