



5307 Yellowstone Rd  
Cheyenne, WY 82009

Phone: 307-632-7677  
Fax: 307-778-8292

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer (if minor parent/guardian employer information) : \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

**Emergency Contact**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

**Type of Visit**

\_\_\_\_ Insurance (Please present card at check in)      \_\_\_\_ Self Pay (Payment due at time of service)

\_\_\_\_ Auto Accident (WE CAN NOT file third party)      Date of accident: \_\_\_\_\_

\_\_\_\_ Worker's Compensation (We can only file State of Wyoming Work Comp) # \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Responsible Party**

Self

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Insurance Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Insurance Address: \_\_\_\_\_



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*(All patients must read and sign form prior to receiving services)*

Thank you for choosing SMART Sports Medicine Center as your healthcare provider. We are dedicated to providing the best possible healthcare and rehabilitation to you, our patient. As a part of our professional relationship, it is important that you understand our consent, financial and HIPAA agreement.

#### **I. CONSENT FOR MEDICAL TREATMENT**

I authorize and consent to medical treatment.

#### **II. FINANCIAL AGREEMENT**

By accepting the services provided to me, I agree to be financially responsible for all charges for treatment.

SMART Sports will file my insurance as a courtesy to me and I am required to provide complete and accurate information.

I understand at the time of service I will be responsible to pay all co-pays and non-covered services, equipment or items not covered by my insurance company. I am responsible for any unpaid insurance balances. I will also be responsible for any attorney fees or collections related charges.

I do hereby authorize my insurance carrier to pay directly to SMART Sports the insurance benefits otherwise payable to me for services rendered.

For Motor Vehicle Accidents: in case of a motor vehicle accident, we only bill your motor vehicle insurance. We do not bill third party claims and we do not accept liens. If you have a third liability claim you will be required to pay at the time of each visit.

#### **III. RELEASE OF MEDICAL INFORMATION**

I authorize SMART Sports Medicine Center to release any medical information necessary to process my insurance claims. I do hereby authorize SMART Sports Medicine Center, its successors and assigns to contact me with any information provided, including but not limited to: cell phone, email, emergency contact and my home address.

#### **IV. MISSED OR CANCELLED APPOINTMENTS**

In order to accommodate other patients who may be waiting for treatment, we require 24 hours notice if your appointment must be cancelled. We reserve the right to charge a **\$35.00** fee for appointments that are not kept or cancelled within 24 hours.

#### **V. HIPAA PRIVACY PRACTICE NOTICE**

I acknowledge that there is a copy of the Notice of Private Practice displayed in the office of Vincent J. Ross, M.D. and on SMART Sport's website www.ssmcwv.com. I also acknowledge that I will be given a copy if requested.

I have read and understand the above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SMART Sports Physical Therapy, Sports Specific training and Advanced Rehabilitation Agreement and Release

This application is submitted with knowledge that the number of participants is restricted by SMART Sports and that it is subject to approval by SMART Sports Management. In consideration of my receiving the use of the facility for Sports Specific Training, Physical Therapy or Advanced Rehabilitation, I agree as Follows:

In accordance with my decision to utilize the facilities of SMART Sports, I do hereby acknowledge that I have received and have read a copy of this agreement and agree to abide by the Rules and Regulations outlined therein. I further acknowledge that these are subject to change at the discretion of SMART Sports.

A person, in attending and using the facilities and equipment therein, does so at his/her own risk. SMART Sports shall not be liable for any damages arising from personal injuries sustained by a person or about the premises. A person assumes full responsibility for any injuries or damages that may occur to participants in, on or about the premises and he/she does hereby fully and forever release and discharge SMART Sports and all associate owners, employee and agents from any and all claims, demands, rights of action or causes of action present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the one's use of the said facilities and equipment thereof.

Physical Therapy

Advanced Rehabilitation

### WAIVER OF LIABILITY

1. Anyone using SMART Sports facility shall undertake any and all risks. The participants shall also be liable for any and all risks. SMART Sports shall not be liable for any injuries or damage to any other participants, or the property of the participants; or be subject to any claim, demand, injury, or damage whatsoever, including, without limitation, those damages resulting from acts of negligence on the part of SMART Sports, its officers, employees or agents. The participant, for himself/herself and on behalf of his/her executors, administrators, heirs, assigns, and assignees and successors, does hereby expressly forever waive, release, and discharge SMART Sports, its owners, officers, employees, agents, assigners and successors from all claims, demands injuries damages, actions or causes of action. SMART Sports shall not be responsible or liable to participants for articles damaged, lost or stolen in or about SMART Sports or lockers for any losses or damages to any property, including, but not limited to automobiles, and the contents thereof. Any damage to SMART Sports property by any participant or guest shall be paid by the participant or guest.
2. Persons use SMART Sports facilities at their own risk. Improper use of fitness equipment and participation in SMART Sports Specific training or Advanced Rehabilitation Programs may be hazardous. Participants are required to abide by SMART Sports Rules and Regulations. SMART Sports reserves the right to take photographs, produce slides and film SMART Sports activities and use these for promotion and advertising. Participant's consent to this policy by virtue of SMART Sports use. If a participant's medical status should change due to an injury, use of SMART Sports facilities is not allowed until reevaluation of participants medical condition has occurred by the medical staff at SMART Sports. Medical approval must be received by participants at all times in order to use the facility.
3. All new participants are subject to the approval by medical staff of SMART Sports for Sports Specific Training, Advanced Rehabilitation Program and Physical Therapy. Participation is open to any individual of good character without regard to race, sex, ethnic background, religion, or physical disability after consultation and evaluation by medical staff.

### USE OF FACILITIES

1. Check In. All persons using the facility are required to check in at the front desk each time they use SMART Sports. Users of Advantage Cards will be required to check in at the front desk of the Fitness Center.
2. Attire and Equipment. Proper attire for all participants using SMART Sports. Shirts and Shoes are required in public areas. Proper etiquette, language and courtesy are to be observed at all times. SMART Sports management may prohibit the use of any equipment it feels is potentially dangerous. Use of any and all fitness equipment is only allowed pursuant to a specifically designed Sports Specific Training Program, Advanced Rehabilitation Program and Physical Therapy. No use is permitted outside the parameter of said program including but not limited to Advantage Cards. SMART Sports retains the right to modify your program at any time.
3. Locker Use. Participants are responsible for the security of their personal property, and may bring their own lock or locking device to secure their lockers while using the facility. All locks must be removed daily. Locks left overnight will be cut off.
4. Pool Use. Participants using the pool will be required to provide their own towel and swim wear. Participants will also be required to shower before entering the Pool and Hot Tub. Use of the SMART Sports pool equipment is for Physical Therapy participants only. Advantage Card, Advanced Physical Therapy and Sports Specific Training participants will need to provide their own equipment.

### Miscellaneous

1. Alcoholic Beverages and Any Illegal Drugs are not permitted
2. There will be NO SMOKING in any area of SMART Sports; including entry areas and any outside area within 30 feet.
3. Person using the facility are required to give notice to SMART Sports of any changes of address, contact information or medical status.
4. SMART Sports makes no guarantee that a participant's condition or health will be improved by se of the facilities or participation in any program offered.

### AMENDMENT OF RULES AND REGULATION AND OPERATION POLICIES

The rules and regulation herein are not inclusive. Other rules and regulations may be posted in and about SMART Sports shall be binding to all members and participants as set out herein in full. SMART Sports may from time to time adopt and/or amend rules and regulations not herein covered, and all members will be obligated to these policies.

Participant/Member's Name Printed \_\_\_\_\_

Signature (Parent or Guardian If under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Name \_\_\_\_\_

Phone \_\_\_\_\_



## WELCOME TO SMART SPORTS MEDICINE CENTER THERAPY

This letter is an introduction to our therapy facility. We would like to make your time spent with us as pleasant as possible. Our staff is made up of Physical Therapists, Physical Therapist Assistants, Certified Athletic Trainers and a Certified Massage Therapist.

To ensure all our patients receive quality care, we have a few requests:

- **Have a current prescription:** A current prescription from your Doctor is required at the time of your Physical Therapy evaluation. If the script is over 30 days old you will need to contact your physician to have it updated.
- **Please wear loose clothing:** Sweat clothes or a T-shirt and shorts will allow freedom of movement. Shoes appropriate for exercise.
- **Show up on time:** If you are late, the therapists reserves the right to shorten your treatment or cancel your visit altogether.
- **Follow the instruction of your therapist:** As part of your care, your therapist may give you a number of exercises to do at home. Your therapist may also give you additional instructions that you need to follow. Not complying with the therapist's instructions may negatively affect your treatment and/or therapeutic benefits.
- **Arrange for child-care:** For safety reasons, children are not allowed in therapy gym or left unattended in the lobby area. Also, because of limited space, guests of patients are asked to remain in the lobby, unless they are accompanying a minor or are needed as medical support for patient.
- **Avoid cancellation:** Please call our office to give us 24 hours notice of cancellation. If you have three cancels or no shows, you will be asked to return to your Doctor for a re-check and a new prescription.
- **We reserve the right to charge \$35.00 for appointments that are not kept or cancelled within 24 hours.**

I have read and understand the information above and agree to comply with these policies.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Identification: \_\_\_\_\_

## PATIENT HEALTH HISTORY

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\*BMI: \_\_\_\_\_  
45 or Greater Requires Anesthesia Consult

ALLERGIES	MEDICATION ALLERGIES	REACTION
Latex <input type="checkbox"/> Yes <input type="checkbox"/> No		
Eggs <input type="checkbox"/> Yes <input type="checkbox"/> No		
Food <input type="checkbox"/> Yes <input type="checkbox"/> No		
Adhesives <input type="checkbox"/> Yes <input type="checkbox"/> No		

CURRENT MEDICATIONS & SUPPLEMENTS	CURRENT MEDICATIONS & SUPPLEMENTS	CURRENT MEDICATIONS & SUPPLEMENTS

**PAST SURGERIES**

DATE	DESCRIPTION	DATE	DESCRIPTION

**MAJOR ILLNESSES AND MEDICAL PROBLEMS**

DATE	DESCRIPTION	DATE	DESCRIPTION

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
MA SIGNATURE

\_\_\_\_\_  
UPDATED

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
MA SIGNATURE

PATIENT NAME \_\_\_\_\_

**CHECK ALL THAT MAY APPLY (SHADED AREAS REQUIRE ANESTHESIA CONSULT)**

ANESTHESIA HISTORY	Y	COMMENT
*Life Threatening/Severe reaction to anesthesia		
*History of Difficult intubation		
*History of Malignant Hyperthermia		
Severe Motion Sickness		
Significant Nausea or Vomiting after anesthesia		
<b>HEART</b>		
*Heart attack (MI)		
*Coronary artery disease (stents/angioplasties/ CABG/ angina)		
*Heart failure/ CHF		
*Internal Defibrillator (AICD)		
*Pacemaker		
Current Heart murmur/ heart valve problems/ valve replacement		
High blood pressure		
Irregular heartbeat		
<b>LUNG/PULMONARY</b>		
Emphysema/ COPD		
Current Oxygen use?		Liters:
Current Bronchitis		
Asthma/ wheezing		
*Sleep apnea/ snoring		
*CPAP/ Bipap use		
<b>NEUROLOGICAL</b>		
*Stroke		
TIA		
Seizures (in past 5 years)		
*Chronic Pain/ daily narcotics		
<b>ENDOCRINE</b>		
Diabetes-use of insulin		<input type="checkbox"/> Insulin <input type="checkbox"/> Pills
Thyroid Disease		
Other		
<b>RHEUMATOLOGY</b>		
Rheumatoid arthritis		
Lupus		
Autoimmune disease		
<b>GASTROINTESTINAL</b>		
GI Bleeding history		
Acid Reflux/ Heartburn		
Hiatal Hernia (stomach)		
<b>RENAL/ HEPATIC</b>		
Kidney Failure/ Dialysis		
Renal Insufficiency		
Urinary Difficulty		
Cirrhosis/ liver disease/ failure		

HEMATOLOGY	Y	COMMENT
*Bleeding disorders/ hemophiliac		
Blood clots (DVTs/ PE)		
*Blood clotting disorder		
*Current blood thinner/ anticoagulants		Last dose:
Anemia		
Cancer		
Sickle Cell Disease		
<b>INFECTION</b>		
HIV / AIDS		
Hepatitis B / C		
Tuberculosis		
*Current Active Infection?		
*MRSA history		
<b>PSYCHIATRIC</b>		
Depression		
Anxiety/ nervous breakdown		
<b>SOCIAL HISTORY: DO YOU?</b>		
Smoke		
Chew tobacco		
Drink alcohol daily		
Ever had withdrawals?		
Use of street drugs		
Marijuana		
<b>REVIEW</b>		
Back/ Neck problems		
Fibromyalgia		
Hearing aids		
Contact lens		
Advanced directives		
False/ capped/ loose teeth		
Body piercings		
Implanted hardware/ metal		
Steroid use in last year		Last dose:
Could you be pregnant?		LMP:
<b>FAMILY HISTORY</b>		
Heart attack		
Diabetes		
Cancer		
Blood clots		
Lung disease/ TB		
Birth defects		
Liver disease		
Kidney disease		
<b>ANESTHESIA CONSULT:</b>		
MD Signature _____	Date/Time _____	