SMART SPORTS Medicine Center

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.ssmcwy.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 LIABILTY

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, it's 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, it's 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 I 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: _____

SMART SPORTS Medicine Center

DATE_____

MEDICAL HISTORY: PLEASE CHECK THE BOX IF YOU HAVE EVER BEEN DIAGNOSED WITH THE FOLLOWING

Name: _____ **Age:** _____ **Date of Birth:** _____

Last Menstrual Period: _____ **Are you pregnant or breast feeding?**

_____

Heart

- ▢ Heart Attack / MI: _____ (Year)
- ▢ High Blood Pressure
- ▢ Irregular Heart Beat (A-Fib)
- ▢ Heart Failure/CHF
- ▢ Pacemaker
- ▢ Valve Replaced
- ▢ Defibrillator
- ▢ Heart Surgery: _____ (Year)
- ▢ Cath ▢ Bypass ▢ Stent

Lungs

- ▢ Emphysema/COPD
- ▢ On Oxygen Liters: _____
- ▢ Asthma
- ▢ Sleep Apnea ▢ Use CPAP
- ▢ Chronic Bronchitis
- ▢ Tuberculosis (TB)
- ▢ Recent Pneumonia
- ▢ Other _____

Endocrine/Kidney

- ▢ Diabetes ▢ On Insulin
- ▢ Thyroid Disease
- ▢ Liver Disease/Cirrhosis
- ▢ Kidney Failure ▢ On Dialysis
- ▢ Other _____

Brain

- ▢ Stroke
- ▢ TIA
- ▢ Seizures (In past 5 years)
- ▢ Depression/Anxiety
- ▢ Bipolar
- ▢ Alzheimer's/Dementia
- ▢ Parkinson's
- ▢ Glaucoma
- ▢ Other _____

Blood/Cancer

- ▢ Blood Clots (DVT in legs, PE)
- ▢ On Blood Thinner: _____
- ▢ Anemia
- ▢ Cancer _____ (Specify)
- ▢ Other: _____

GI System

- ▢ GI Bleed
- ▢ Ulcer
- ▢ Acid Reflux/Heartburn
- ▢ Hiatal Hernia
- ▢ Other: _____

Rheumatology

- ▢ Rheumatoid Arthritis (RA)
- ▢ Lupus (SLE)
- ▢ Fibromyalgia
- ▢ Other: _____

Infections

- ▢ HIV/AIDS
- ▢ Hepatitis B or C
- ▢ MRSA
- ▢ Current Active Infection
- ▢ Other: _____

Social History

- ▢ Smoke: _____ packs/day
- ▢ Chew Tobacco
- ▢ Alcohol use: _____ drinks/day
- ▢ Use Street Drugs/Marijuana
- ▢ Withdrawal from alcohol/drugs

Additional Medical Information:

_____

_____

_____

_____

_____

_____

_____

_____

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  I understand that my insurance policy is an agreement between my insurance company and myself and that I am responsible for my knowledge of the policy provisions, including co-pays, non-covered services, and network inclusions.

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

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- **RELEASE OF MEDICAL INFORMATION**

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- **MISSED OR CANCELLED APPOINTMENTS**

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

- **HIPAA PRIVACY PRACTICE NOTICE**

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I have read and understand the above.

Signature_____Date_____

PATIENT HEALTH HISTORY

Patient Name: _____ Preferred Name: _____ Date: _____

Age: ____ ☐ Male ☐ Female Height: _____ Weight: _____

_____

Allergies		Medication Allergies	Reaction
Latex	☐ Yes ☐ No		
Eggs	☐ Yes ☐ No		
Food	☐ Yes ☐ No		
Adhesives	☐ Yes ☐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