SMART SPORTS Medicine Center

5307 Yellowstone Rd Phone:307-632-7677
Cheyenne, WY 82009 Fax:307-778- 8292

Patient Information

Last Name:_____First Name: _____Middle 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:_____

5307 Yellowstone Rd
Cheyenne, Wy 82009
Phone: 307-632-7677
Fax: 307-778-8292

SMART SPORTS Medicine Center

(All patients must read and sign the 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 the case of a motor vehicle accident, we will only bill, motor vehicle insurance. **We do not bill third party claims and we do not accept liens**. If you have a third party liability claim you will be required to pay at the time of each visit.

III. RELEASE OF MEDICAL IN FORMATION

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

IV. 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 Sheena Pacheco FNP And on SMART Sport's website: www.Smartsportsmed.com. I also acknowledge that I will be given a copy if requested.

I have read and understand the above.

Signature: _____Date: _____

Vincent "Skip" Ross M.D.
Board Certified
Sports and Family Medicine

Sheena Pacheco FNP
Primary and Family Medicine

Dear Patients:

This is to inform you that Smart Sports Medicine PC and LLC has instituted a Failed or canceled appointment policy regarding missed and/or canceled appointments.

It is our goal to continue to provide you with excellent Sports Medicine, Family Medicine, and Physical therapy services. Failed appointments and appointments that are canceled on short notice waste valuable appointment time that other patients could utilize. If you are unable to keep your appointment, please notify our office at least 24 hours prior. This allows us to offer your appointment to another patient who may be in need of urgent care.

Smart sports will charge a fee of $35.00 for appointments if you miss an appointment or fail to cancel giving 24 hour notice. Please be informed that your insurance company will not cover this fee and it will be entirely your responsibility.

Sincerely,
Smart Sports Medicine Center.

Date: _____

Patient Signature (or parent or guardian):_____

Smart Sports Witness:_____

_____ I decline to authorize the release of my protected information as outlined by H.I.P.P.A.

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Smart Sports Medicine Center and Physical Therapy to release my records and any information requested to the following individuals.

1. _____Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)

☐ I authorize you to leave a detailed message on my home or cell number regarding appointments

☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

☐ I authorize you to leave a message with anyone who answers the phone

☐ Messages may only be left with _____

_____
Patient Name (Please print)

_____
Date

_____
Patient Signature

SMART SPORTS Medicine Center

PATIENT HEALTH HISTORY

Patient Identification:

Patient Name:_____ **Preferred Name:**_____ **Date:**_____

Age:_____ Gender: ☐**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

_____ _____ _____

UPDATED PATIENT SIGNATURE MA SIGNATURE

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 breastfeeding?**_____

Heart

- ☐ Heart Attack/ MI: _____(Year)
- ☐ Blood Pressure
- ☐ Irregular Heart Beat (A-Fib)
- ☐ Heart Failure/CHF
- ☐ Pacemaker
- ☐ Valve Replaced
- ☐ Heart Surgery: _____(Year)
- ☐ Cath ☐By Pass ☐Stent

Lungs

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

Endocrine/Kidney

- ☐ Thyroid Disease
- ☐ Liver Disease/Cirrhosis
- ☐ Kidney Failure
- ☐ On Dialysis
- ☐ Diabetes
- ☐ 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
- ☐ Lupus(SLE)
- ☐ Fibromyalgia
- ☐ Other:_____

Infections

- ☐ HIV/AIDS
- ☐ Hepatitis B or C
- ☐ MRSA
- ☐ Current Active Infections
- ☐ Other:_____

Social History

- ☐ Smoke :_____Pack/Day
- ☐ Chew Tobacco
- ☐ Alcohol Use: _____Drinks/day
- ☐ Use of street drug/Marijuana
- ☐ Withdrawal from Alcohol/Drugs

Additional Medical Information:

_____

_____

_____

_____

_____

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, Physical Therapy Technicians, Certified Athletic Trainers and a Certified Massage Therapist.

To ensure all our patients receive the best quality of 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 and shoes appropriate for exercise.
- **Show up on time:** If you are late, the therapists and staff reserve the right to shorten your treatment or cancel the 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 the 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 patients.
- **Avoid cancellation:** Please call our office to give us 24hours notice of cancellation. If you have three cancellations or no shows, you will be asked to return to your Doctor for a recheck and a new prescription.
- **We reserve the right to charge $35.00 for appointments that are not kept or canceled within 24 hours.**

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

Patient 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 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 here by 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 there in, 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 and he/she does here by 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 the 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 what so ever, 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 on the behalf of his/her executors, administrators, heirs, assigns, and assignees and successors, does here by expressly forever waive, release, and discharge **SMART Sports,** it's owners, officers, employees, agents, assignees 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 there of. Any damage to **SMART Sports** property by any participant or guest shall be paid by the participant or guest.
2. Persons using 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 re-evaluation 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 the 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 parameters 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 swimwear. 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. Persons 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 use of the facilities or participation in any program offered.

AMENDMENT OF RULES AND REGULATION AND OPERATION POLICIES

The rules and regulations herein are not inclusive. Other rules and regulations may be posted in and about SMART Sports and 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 covered herein, and all members will be obligated to these policies.

_____
(Participant/Member's Name Printed) **Date**

_____
(Signature: Parent or Guardian if under 18 years of age)

_____
Smart Sports Witness **Date**

_____
(Emergency Contact Name) **(Phone Number)**

5307 Yellowstone Rd
Cheyenne, WY 82009
Phone:307-632-7677
Fax: 307-778-8292

Smart Sports Physical Therapy

New Evaluations and Post Op Appointments

Have you done Physical Therapy during this calendar year at any other facility besides Smart Sports? (Circle one)

☐ Yes Or ☐ No

If you answered yes to the previous question Please answer the following.

Where did you receive Physical Therapy?_____

How many Visits did you receive?_____

Patients Name :_____

Patient Signature (If a Minor Parent or guardian): _____

Date:_____