WEST BAY
SPORTS MEDICINE & REHABILITATION CENTER
800 South Claremont St. Suite 106
San Mateo, CA 94402
Tel: 650.685.4800 ● www.westbaysmrc.com ● Fax: 650.685.4802

Patient Acknowledgement Form

I have read and fully understand *West Bay Sports Medicine and Rehabilitation Center* Notice of Information Practices. I understand *West Bay Sports Medicine and Rehabilitation Center* may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations, if I notify the practice. I also understand that *West Bay Sports Medicine and Rehabilitation Center* will consider requests for restrictions on a case by case basis, but do not have to agree to requests for restrictions.

I understand that I may have a copy of the Notices of Privacy Procedures at my request.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in *West Bay Sports Medicine and Rehabilitation Center* "Notice of Patient Privacy Procedures Practices." I understand that I may revoke this consent by notifying the practice in writing at any time.

Print Name: _____

Sign Name: _____

Date: _____

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Patient Name: _____ Date of Birth: _____

We are committed to providing you with the best possible care. As a courtesy to our patients, we will also submit your insurance claims for you. Please understand that you are responsible for your bill for services, in its entirety. If you would like us to submit bills to your insurance company on your behalf, please provide us with a copy of your insurance card and complete billing insurance. Incomplete information may lead to payment delays or your claims being denied by your insurance carrier, which will necessitate us billing you for any outstanding balance. Please verify that we are contracted with your insurance carrier. Please understand that it is your responsibility as the patient to know your own insurance coverage.

We have called your insurance company as a courtesy and were provided with the following information. Your insurance company does not guarantee payment or the accuracy of this information. They quoted the following:

Deductible: $_____ Copay: $_____ Approved visits/visit max: _____

Deductible met: $_____ Co-Insurance: _____

Please initial here to verify your knowledge of your insurance benefits: _____
Initial here

Payment is expected at the time of service for any amount determined to be uncovered by your insurance (i.e. co-payments, co-insurance plans and deductible).

In the event that you do not have medical insurance, payment will be expected at the time of service. We realize that temporary financial problems may affect timely payment of your account. If this situation should occur, please contact us immediately to assist you with the management of your account.

The nature of this office is to give personal, individual care and an appointment is your reserved tine. Thus, we request at least 24-hour notice of cancellation or change of appointment. Due to the length of time we schedule with our patients, there will be a $40.00 fee charged for any broken appointments without proper notice. _____
initial here

I hereby instruct and direct my insurance company to make payment to **West Bay Sports Medicine & Rehabilitation Center**. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. I also authorize the release of any information pertinent to my case to any insurance adjustor or attorney involved in this case.

A photocopy of this Assignment shall be considered as effective and valid as the original. I have read, understand and agree to the above financial policy. In addition, I authorize West Bay Sports Medicine and Rehabilitation Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Patient/Policyholder Date

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NAME: _____

Please mark any of the following whose care you're under (mark all that apply)
___ Medical Doctor (MD) ___ Physical Therapist ___ Osteopath ___ Chiropractor ___Psychiatrist/Psychologist Other _____

Have you EVER been diagnosed with any of the following conditions?

YES	**NO**	**Cancer (if Yes, what kind _____)**	**YES**	**NO**	**Rheumatoid Arthritis**
YES	**NO**	**Heart Problems (if YES, what kind _____)**	**YES**	**NO**	**Arthritic conditions**
YES	**NO**	**Do you have a Pacemaker?**	**YES**	**NO**	**Depression**
YES	**NO**	**High Blood Pressure**	**YES**	**NO**	**Hepatitis**
YES	**NO**	**Circulation Problems**	**YES**	**NO**	**Stomach Ulcers**
YES	**NO**	**Respiratory Problems**	**YES**	**NO**	**Kidney Disease**
YES	**NO**	**Stroke**	**YES**	**NO**	**Blood Clots**
YES	**NO**	**Chemical Dependency (i.e. alcoholism)**	**YES**	**NO**	**Osteoporosis**
YES	**NO**	**Thyroid problems**	**YES**	**NO**	**Current Infection**
YES	**NO**	**Diabetes**			
YES	**NO**	**Multiple Sclerosis**	**Other: _____**		

Please list any previous **SURGERIES** (include date & reason)

Date:	Surgery	Date:	Surgery
1)_____	_____	2)_____	_____
3)_____	_____	4)_____	_____

Please describe any **ORTHOPEDIC injuries** for which you have been treated (fractures, dislocations, sprains)

Date:	Injury	Date:	Injury
1)_____	_____	2)_____	_____
3)_____	_____	4)_____	_____

Please list **ALL MEDICATIONS** you are currently taking

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Have you recently noted:

YES	**NO**	**sudden, unexpected weight loss/gain**	**YES**	**NO**	**numbness in pelvic region**
YES	**NO**	**fever/chills**	**YES**	**NO**	**dizziness/lightheadedness**
YES	**NO**	**night sweats**	**YES**	**NO**	**double vision**
YES	**NO**	**nausea/vomiting**	**YES**	**NO**	**difficulty swallowing**
YES	**NO**	**numbness/tingling**	**YES**	**NO**	**difficulty with speech**
YES	**NO**	**urinary incontinence**	**YES**	**NO**	**unusual joint/muscle swelling**
YES	**NO**	**loss of bowel/bladder control**	**YES**	**NO**	**Are you pregnant?**
YES	**NO**	**n coordination with walking**	**YES**	**NO**	**Do you have a fracture?**

How did you hear about us?_____

Signature: _____ **Therapist initials:** _____