VELO Sports Rehab

New Patient Intake Form

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Address:_____City/Zip_____

Phone (cell/home):_____Email: _____

Appointment Reminder Preference: ○ Text message ***or*** ○ Phone Call

Emergency Contact:_____ Phone:_____

Employer: _____

Occupation:_____How Long? _____

Height: _____ Weight: _____

Marital Status: ○Single ○Married ○Other Children: ○Y ○N Ages: _____

Who may we thank for referring you to our office: _____

Medical History: check all that apply (past or present)

○Allergies
○Osteoarthritis
○Rheumatoid disease/
○Inflammatory Arthritis
○Osteoporosis/Osteopenia
○Artificial bones/joints
○Asthma
○High/Low blood pressure
○Anemia
○Migraine/Headache
○Chest pain
○Shortness of breath
○Heart Attack/ Stroke
○Lung Disease
○Thyroid problems
○Cancer
○Diabetes
○Other_____

○Stomach/GI disorders
○Kidney problems
○Depression/Anxiety
○Alcohol/Drug/Tobacco use
○Neurological condition (MS/ALS, etc)
○STD
○Nausea/Vomiting
○Fever/Chills/Sweats
○Weight (up/down) changes
○Numbness/Tingling
○Skin Rash
○Dizziness
○Muscle weakness
○Balance problems
○Vision changes
○Pregnancy/Birth control
○HIV/Aids

Please list any serious accidents or surgeries with dates:

_____

_____

Family Health History: _____

_____

Medications/Supplements:

_____

_____

Reason for **today's** visit (work injury, auto accident, sports/training injury, etc.):

_____

_____

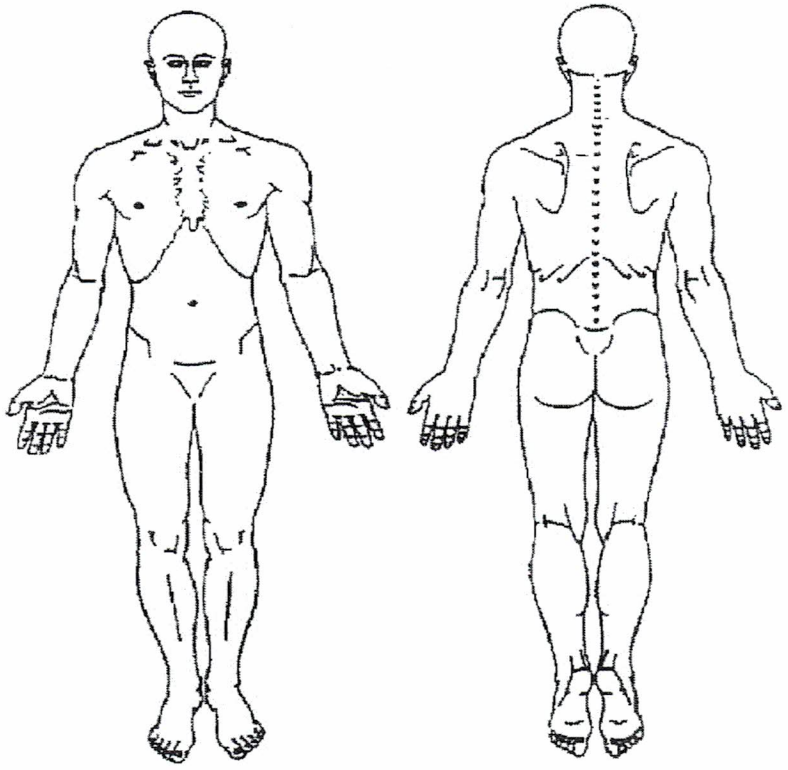
Have you received any imaging (X-ray, MRI, CT, Ultrasound, etc.)? _____

_____

Does anything make your symptoms worse? _____

Better? _____

Please circle on the body where you are feeling symptoms:



Is there anything else about your health that you would like the doctor to know?

_____

_____

VELO Sports Rehab

No Show & Cancellation Policy:

At Velo Sports Rehab, we strive to render excellent quality of care to our patients. When an appointment is scheduled, this time has been set aside especially for you. When an appointment is missed, this time is lost that our providers could have used to serve other patients on our waiting list.

If you cancel or no show to your appointment with less than 24 hours notice, you will be charged a **$75.00** fee. If you are more than 10 minutes late, we may ask you to reschedule your appointment. Failure to arrive at two or more appointments may result in the inability to schedule future appointments. If you late cancel or no show more than once due to sickness, Covid exposure or the like, you will be charged our late cancellation fee of $75.00.

_____ _____

Printed Name Signature

Billing & Financial Policy:

You are responsible to provide the full payment for any services rendered at Velo Sports Rehab and payment is due at the time of service. Statements are sent out when there is a balance after insurance has processed the claim *and* after any payments made have been posted to your account.

Please remember your insurance policy is a contract between you and your insurance company. As a courtesy, our office provides estimated treatment costs, estimated patient portion, and estimated insurance portion. These estimates are not a guarantee of payment, but rather an estimate referencing the information gathered online from your insurance company.

If remaining balances are not paid within 15 days, your account will be turned over to a collection agency.

You acknowledge that any package purchases are non-refundable. They never expire and can be used between family members.

_____ _____

Printed Name Signature

Dated: _____

VELO Sports Rehab

HIPAA Privacy Practice Notice

Velo Sports Rehab:

a. Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History. Velo Sports Rehab will not share your health information unless you request us to do so verbally or in writing.
b. Under the privacy rule, may be required by State law to grant greater access or maintain greater restrictions provided under federal law.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all your Personal Health History that it maintains.
e. Will distribute any revised Privacy Notice 60 days prior to implementation.
f. Will not retaliate against you for filing a complaint.

I have read and agree to the terms of the HIPAA Privacy Practice notice.

_____ _____
Signature Date

Would you like to authorize an individual to access your medical records? (ie: Spouse, Attorney,etc.)

○ **Yes** ○ **No** (If yes, list their full name and relationship to you below)

Name:_____ Relationship:_____

Name:_____ Relationship: _____

Patient Signature: _____ Date _____