SMART Therapy
SPORTS MEDICINE & REHABILITATIVE THERAPY

Medical History

Name: _____ Date: _____

Medical History:

General Health (Circle One): Excellent Good Fair Poor

Have you had any **medical problems** or hospitalizing in the past year (circle): **YES** **NO**
If yes, please specify:

_____

_____

_____

_____

Surgical History:

Date:	**Procedure:**

Are you currently receiving Home Health Care or Hospice: YES NO
If so, please provide the name and address of company:

_____

Prescription Medications (Including over the counter medications):

_____

_____

_____

_____

Past Injury/Problem History

Date:	**Injury/Problem:**	**Treatment:**

Present Injuries/Complaints

Date of Injury:	Body Part:	Symptoms at the time of onset:

Present/Past Medical Conditions (Circle applicable):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulator Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/Implant	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Headaches	Y	N	Thyroid Problems	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N
Weakness	Y	N	Night Pain	Y	N
Dyspnea	Y	N	Seizure Disorder	Y	N

Other:

_____

_____

Please circle the word (s) that best describe your pain which brought you to therapy:

pain sharp dull aching throbbing burning stinging piercing

I have filled out the above questionnaire to the best of my ability and give my consent to SMARTherapy for therapy treatment and to align a plan of care.

_____ _____

Patient or Guardian Signature **Date**

SMART Therapy
SPORTS MEDICINE & REHABILITATIVE THERAPY

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Fax: 301.951.8598

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Suite 610
Washington, DC 20006
Phone: 202.540.5999
Fax: 202.540.5690

5215 Loughboro Road, NW
Suite 200
Washington, DC 20016
Phone: 202.787.5620
Fax: 202.787.5606

SMARTherapy Cancellation Policy

We understand that unforeseeable events may occur that require rescheduling of your appointment. At SMARTherapy we require at least a **24 business hour** notification if you are unable to keep your scheduled appointment. This courtesy will allow us to maximize available time with our therapists to accommodate our patients. We do realize that emergencies arise, however we must enforce this policy due to excessive no-shows. If you would like to request special consideration for a no-show or less than 24 hour cancellation, please contact the site supervisor at your therapy location.

Cancellation of appointments:

- **Failure to give a 24 hour** notice to cancel or reschedule an appointment for the ***first*** time will result in a **$25 fee**.
- **Subsequent cancellations** of less than 24 hour notice will result in a **$95 fee** for **each occurrence**.

No-show/late appointments:

- All patients who **fail to show** for a scheduled appointment (no-show) will be assessed a **$95 fee** for each occurrence.
- The therapist schedules are curbed so each patient may be seen at their requested time. If you are over 15 minutes late for your appointment, you may be asked to reschedule.

Patients with excessive no-shows may be asked to provide a credit card prior to booking future appointments.

As a courtesy to our SMARTherapy patients, we will attempt a reminder call 24-48 hours prior to the scheduled appointment. Please provide current contact information to our front desk staff.

Signature:_____ **Date:**_____

Int._____ **Date:** ____/____/____ **- Service Rendered**

Int._____ **Date:** ____/____/____ **- Service Rendered**

Int._____ **Date:** ____/____/____ **- Service Rendered**

Int._____ **Date:** ____/____/____ **- Service Rendered**

SMARTherapy Consent Waiver

Patient Name:_____ **Date of Birth**:_____

Present Injury/Complaint:_____ **Date of Injury**:_____

Rate your pain from 1-10 (10 being the worst): at worst _____ at best _____ right now _____

Consent to Treat

I give my consent to SMARTherapy for therapy treatment and to align a plan of care.

_____ _____

Signature Date

I acknowledge that I have been presented with a copy of the Notice of Privacy Practices for SMARTherapy.

_____ _____

Signature Date

Consent to Leave Phone Messages and Access to Medical Records

I understand that as part of my health care and treatment, SMARTherapy may need to reach me by phone.

☐ **I DO** authorize SMARTherapy to leave a message on my voice mail/answering machine(s) regarding communication of my health care/treatment such as appointment confirmation calls, clinical and/or billing needs, etc.. (check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone Preferred Contact Number:_____

☐ **I DO NOT** authorize SMARTherapy to leave a message on my home, cell, or work phone regarding communication of my health care/treatment such as appointment confirmation calls, clinical and/or billing needs, etc.. **I understand that selecting this option may result in delayed communication of pertinent treatment information such as appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.**

List below any person(s)/family member(s) whom you authorize access to your medical records and authorize us to leave a detailed message with regarding all aspects of your medical chart, health condition, medications, and financial history.

Name: _____ Contact Number:_____ Relationship:_____

Name: _____ Contact Number:_____ Relationship:_____

Patient or Legal Guardian Signature:_____

SMARTherapy BCBS Waiver {non-refundable}

Dear Patient,

Please be advised, SMARTherapy does not participate with Blue Cross Blue Shield insurance plans. As a courtesy to our patients, we will submit the charges for therapy services to your insurance provider on your behalf. After your claim is processed, we will review the explanation of benefits (EOB) from the insurance carrier. Based on your insurance coverage we will determine what the patient responsibility is for each appointment. The patient's responsibility will be determined by their specific insurance plan and what charges the insurance applies to the out-of-network benefits.

Please note: **there is an encounter fee of $70 for each therapy appointment**. It is required that this fee be paid up-front, at the time of service. The encounter fee will be inclusive of any co-insurance and/or co-pays based on your out-of-network coverage. As the patient, you will be responsible for fulfilling your deductible (as assigned by your insurance plan) and any co-insurance/co-pays over the encounter fee amount.

Please be aware, Blue Cross Blue Shield may send payment for services rendered directly to you. We ask that you please remit those insurance payments to us within 10 days of receipt so we may maintain proper records on your account. Please utilize our business office address, **5454 Wisconsin Avenue, Suite 1555, Chevy Chase, MD 20815**, to submit insurance checks, or you may bring them directly into the office during regular business hours. Please ensure that all checks have been properly endorsed and that the corresponding explanation of benefits is included when submitting an insurance check. We cannot properly reconcile your account without both the explanation of benefits and insurance payment. You may endorse the insurance checks over to SMARTherapy or provide a personal check for the same amount.

Due to delays in insurance claims processing, you may receive a statement for the *full balance on your account.* You will be responsible for the full balance pending the following of the SMARTherapy billing practice outlined above.

Please note, if SMARTherapy does not receive your explanation of benefits and checks in a timely manner, this office reserves the right to restrict future appointments.

This waiver also certifies that you confirm the medical insurance information provided to our offices is correct. You authorize the release of any necessary information, including medical information for this or any related claim, to your insurance company. This authorization will be used in place of an original authorization, if already on file, and may be revoked in writing by you or the insurance company at any time.

By signing below, you acknowledge and understand this policy. If you have any further questions, please do not hesitate to contact our business office Monday- Friday, 9:00am – 5:00pm at (240) 482-4556.

_____ _____

Patient Signature (or Parent/Guardian) Date

_____

Print Name