VELO Sports Rehab

# New Patient Intake Form

Date:_____

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Address:_____City/Zip_____

Phone (cell/home):_____Email: _____

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

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):

_____

_____

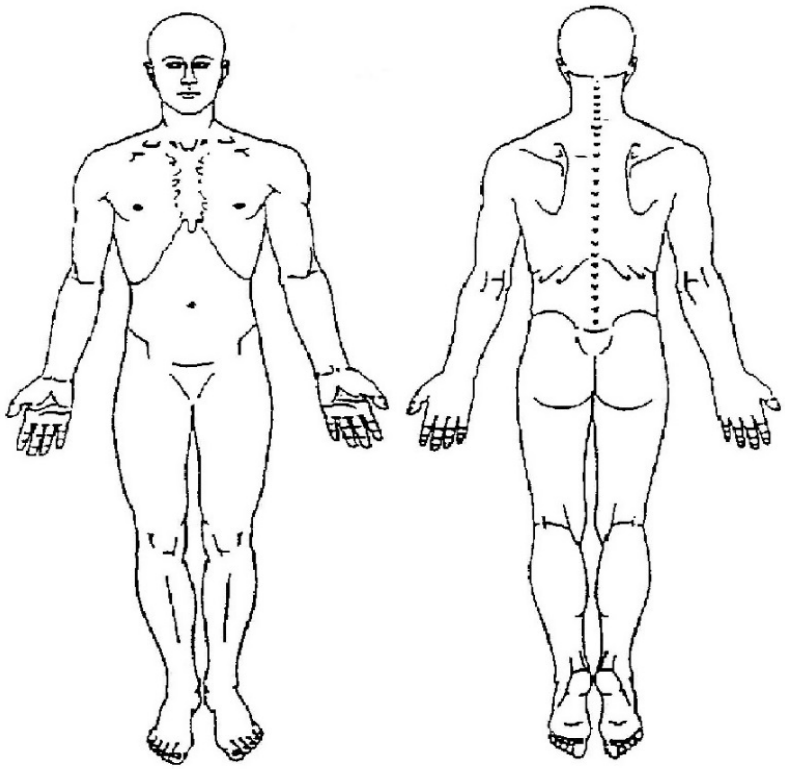
Have you received any imaging (X-ray, MRI, CT, Ultrasound, etc.): _____

_____

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?

_____

_____

**No Show & Cancellation Policy**:

Velo Sports Rehab appreciates 24 hours prior notice when cancelling an appointment. If you cancel with less than 24 hours notice or miss your appointment, you will be charged **$60.00** for a visit with a doctor and **$90.00** for a massage. If you are more than 10 minutes late to your appointment we may ask you to reschedule. By signing below, you acknowledge that you understand and agree to the no show and cancellation policy.

_____ _____

Printed Name Signature

_____

Date

**HIPAA (Privacy Practices)**:

I understand and acknowledge that I have received a copy of the HIPAA/Notice of Information Practices from Velo Sports Rehab and I understand it entirely. *Please see attached form*.

_____ _____

Signature Date

**Financial Policy**:

1. We will bill your insurance company as a courtesy to you. You are ultimately responsible for your bill regardless of insurance coverage. Please keep the front desk informed about any changes to your insurance.
2. Payment for deductible, co-insurance and copay's are expected at the time of visit.
3. We do offer a *time of service* discount to patients that do not have health insurance.
4. Please don't hesitate to call or email our office with any questions regarding your bill.

_____ _____

Signature Date

# 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.