SPORTS MEDICINE & REHABILITATIVE THERAPY

5454 Wisconsin Avenue
Suite 1555
Chevy Chase, MD 20815
Phone: 301.951.8593
Fax: 301.951.8598

2021 K Street, NW
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

Blue Cross Blue Shield/Carefirst Submit Service Waiver

Please be advised, SMARTherapy does not participate with Blue Cross Blue Shield insurance plans and will no longer submit to your insurance provider. I confirm that I am choosing to seek treatment under my own financial obligation. I understand that I am responsible for payment of services at the time of my care with SMARTherapy. I understand that I will submit charges from SMARTherapy to my insurance provider or responsible party. By signing below, I acknowledge and understand this policy.

Signature: _____ Date: _____

5454 Wisconsin Avenue
Suite 1555
Chevy Chase, MD 20815
Phone: 301.951.8593
Fax: 301.951.8598

2021 K Street, NW
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 **Today's Date:** _____/_____/_____

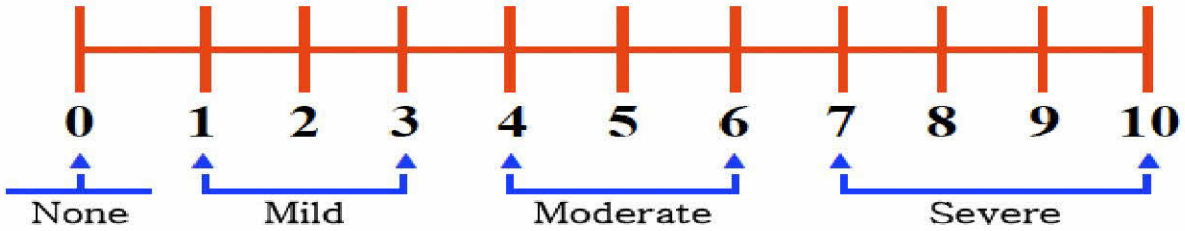
Patient Name:_____**DOB:**_____/_____/_____

Height: _____ft. _____in. **Weight:** _____lbs **BMI:** _____

LIST OF CURRENT MEDICATIONS: List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (Viagra, Albuterol, Nitroglycerin, etc.)

Medication	**Dose**	**Manner taken (oral, topical, injected, etc.) & Frequency**

- **How would you rate your pain today with 10 being the worst? Please circle one**



- **In the past year, which of the following have you experienced: Please circle one**

No Falls **One Fall – No Injury** **Two or more Falls** **Fall with Injury**

Smoking Status (circle): **Current Smoker** **Never Smoker** **Former Smoker**

Signature: _____ **Date:** _____

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 _____

Is your injury Auto or Work related? _____

Consent to Treat

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

Health History

I have reviewed my health history and confirm that the information listed is complete, correct, and/or I have made the necessary changes to update my health information.

Patient or Legal Guardian Signature: _____

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**