Dynamic Spine & Sport

WELCOME!

All of us at Dynamic Spine & Sport Rehabilitation would like to thank you for the opportunity to be an integral part in your recovery!

We pride ourselves in our complete patient care and are committed to your total rehabilitation. After your initial consultation with our Physical Therapist, you will be put in an individually tailored routine designed with your specific needs in mind. This will include manual/hands on techniques performed by a skilled therapist, Pilates from our well trained and certified staff technicians (when appropriate), modalities as indicated, and an individual workout plan with instruction on safe form and technique.

Everyone at Dynamic Spine & Sport is committed to your total health and well being. Once you have reached your physical therapy goals and completed your course of treatment, you will be offered the opportunity to continue in our post discharge community based preventative care plans with either private or group Pilates sessions or with a personal fitness trainer at a reduced rate.

Comfortable workout attire is appropriate for your treatment sessions. In addition, please refrain from wearing heavy cologne or perfumes, as some people may be sensitive to the smell. Please try to be on time so as to maximize benefit of your treatment time and to allow us to operate smooth for all of our clients. There is a 24-hour cancellation policy, so please let us know as soon as possible if you need to make any change to your appointment. We know your time is valuable and want to make sure that we are able to maximize the time we have to attend to each and every individual that comes to our facility.

We look forward to working with you and hope to make your experience as fulfilling and effective as possible.

Thank you for letting us serve you.

Dynamic Spine & Sport Rehabilitation

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DYNAMIC SPINE & SPORT REHABILITATION BILLING SERVICE PRIVATE AND GROUP ACCIDENT HEALTH INSURANCE

PATIENT:_____

I hereby instruct and direct that _____
Insurance Company to pay by check made out and mailed to:

Dynamic Spine & Sport Rehabilitation
8951 W. Sahara Ave., Ste. 190
Las Vegas, NV 89117

OR

If my current policy prohibits direct payment to the treating facility, then I hereby also instruct and direct you to make out the check for payment of services to me and mail it as follows:

C/O Dynamic Spine & Sport Rehabilitation
8951 W. Sahara Ave., Ste. 190
Las Vegas, NV 89117

I instruct my insurance company to pay, in accordance with my above instructions, all the professional or medical expense benefits allowable, and otherwise payable to me under my insurance policy as payment towards the total charges for the professional service rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the abovementioned assignee, and I have agreed to pay, in a current manner, any balances of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

_____/_____/_____
Date

_____ _____
Signature of Policyholder Witnessed By

_____
Signature of Claimant, if other than Policyholder

Dynamic Spine & Sport Rehabilitation

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable and customary fee charged in this area by physical therapists of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **You will be expected to pay your insurance co-payment at each visit.** There will be a $25 service charge for any checks returned to our office.

Our office will make every effort to verify eligibility and benefits with your health insurance company. **The amount quoted to us over the telephone is NOT a guarantee of payment nor determination of benefits. It is an estimated amount that you are responsible for. It is ultimately your responsibility to know the type of insurance plan/policy you are enrolled in and whether or not we are contracted providers.** The exception is for those patients with work-related claims covered by Worker's Compensation or personal injury patients covered by attorney liens. These patients are not responsible for their bills unless their claim has been denied.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to DYNAMIC SPINE & SPORT REHABILITATION for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage.

I also authorize DYNAMIC SPINE & SPORT REHABILITATION to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

_____ _____

Patient's or Responsible Party's Signature Date

_____

Patient's or Responsible Party's Printed Name

Dynamic Spine & Sport

Message from Joe

Dynamic Spine & Sport Rehabilitation serves to provide quality health care, in a warm and inviting environment, for patients of all ages and disabilities, in a gentle and caring manner, with ultimate concern for the individual as a whole being. At Dynamic, we understand that healthy and successful healing is marked by usually continuous and productive activity or change and that this change applies not only to the motion but also to the equilibrium of the body. The complete and holistic treatment of the mind and body will be accomplished through the use of physical therapy rehabilitative modalities to include: manual techniques, physical agents, and physical activity at a level that is appropriate to the individual and will be progressed as able per tolerance. Therapeutic exercise and neuro re-education are implemented through carefully constructed protocols to fit the needs of the individual and training in Pilates is incorporated to provide a healthy and effective alternative to standard exercise techniques. These techniques employ physical force and energy by the individual that promote positive change, growth, and activity. Individuals will be educated on post discharge plans to further maximize healing and progression by providing the knowledge and physical strength necessary to avoid recurrence of signs and symptoms and promote good health for the future. At Dynamic we know that preventative care is an ongoing process and so post discharge programs are available to enable continued progress and success for the individual under the supervised watch of our professionally trained, caring, and friendly staff.

Dynamic Spine & Sport Rehabilitation

Patient Information & Referring Physician Information

IN AN EFFRT TO GIVE YOU THE BEST CARE POSSIBLE, YOU MUST KEEP ALL APPOINTMENTS WITH YOUR REFERRING PHYSICIAN DURING YOUR TREATMENT AT DYNAMIC SPINE & SPORT REHABILITATION. PLEASE BE AWARE THAT YOU WILL NEED TO SEE YOUR REFERRING PHYSICIAN BEFORE YOUR CURRENT PHYSICAL THERAPY SCRIPT EXPIRES IN ORDER TO AVOID DISRUPTION OF YOUR PRESENT TREATMENT.

Name: _____ Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____ Zip code: _____

E-Mail Address:_____ Social Security No.: _____-____-_____ Sex: M/F

Phone numbers: Home: ( )_____-_____ Cell: ( )_____-_____ Work: ( )_____-_____

Employer:_____ Occupation:_____

Emergency Contact:_____ ( )_____-_____ Relationship:_____

REFERRING PHYSICIAN INFORMATION AND FOLLOW-UP APPOINTMENTS:

Name of referring physician:_____ Next appointment date: _____/_____/_____

Date of injury or onset of pain: _____/_____/_____ Surgery:_____/_____/_____

If you have received any of the following treatments during the calendar year please write the number of visits for each:

Occupational Therapy:_____ Speech Therapy:_____

Chiropractic:_____ Physical Therapy:_____

Insurance Information and Billing Agreement

INSURANCE INFOMRATION: ***Primary Insurance***

Policyholder's Name:_____ Policyholder's D.O.B:_____/_____/_____

Relationship to Patient:_____ Policy/Group Number:_____/_____

Name of Insurance company:_____ Insurance Phone No:( )_____-_____

INSURANCE INFOMRATION: ***Secondary Insurance***

Policyholder's Name:_____ Policyholder's D.O.B:_____/_____/_____

Relationship to Patient:_____ Policy/Group Number:_____/_____

Name of Insurance company:_____ Insurance Phone No:( )_____-_____

If using insurance, do you have a doctor's prescription/referral for physical therapy? _____
In addition to insurance payment, my co-payment is $_____ which is due at the beginning of each treatment.

A **$25.00** fee will be applied to your account for returned checks. **A 24-hour advance notice** is required to cancel an appointment and avoid a **$35.00** late cancellation fee, which will not be charged to your insurance company and will be due on the day of your next appointment. I understand my insurance limitations for coverage and will not exceed my financial capability to pay for services rendered at Dynamic Spine & Sport Rehabilitation.

Signed:_____ Date:_____/_____/_____

Significant/Previous Medical History Questionnaire

Please circle any disorders you may have experienced or been diagnosed with in order to prevent exacerbation of the condition and to allow us to maintain a safe environment for you at all times during your treatment (all information given is confidential):

1) Cancer/Tumors
2) Cardiac Condition
3) Pacemaker Implant
4) High Blood Pressure
5) Blood Clots
6) Asthma or Breathing Disorder
7) Osteoporosis/Osteopenia
8) Diabetes
9) Osteoarthritis
10) Acute Inflammatory Disease
11) Dizziness/Double Vision/Fainting Attacks/Difficulties with Speech, Swallowing, or Talking
12) HIV
13) Hepatitis A/B/C
14) Bowel/Bladder Condition
15) Unexpected Weight Loss/Gain
16) Skin Disorder
17) Sensory Changes
18) Surgery
19) Metal in Body
20) Possible Pregnancy
21) Phlebitis
22) Thrombosis
23) Varicose Veins
24) Lack of Normal Skin Sensation
25) Leg or Knee Pain
26) Low Back Pain
27) Mid Back Pain
28) Neck or Shoulder Pain
29) IUD
30) STD
31) Other _____

_____

Medications: _____

For the items circled, please give a brief explanation: _____

_____

_____

_____

_____

The above information is accurate and true to the best of my knowledge.

_____ _____

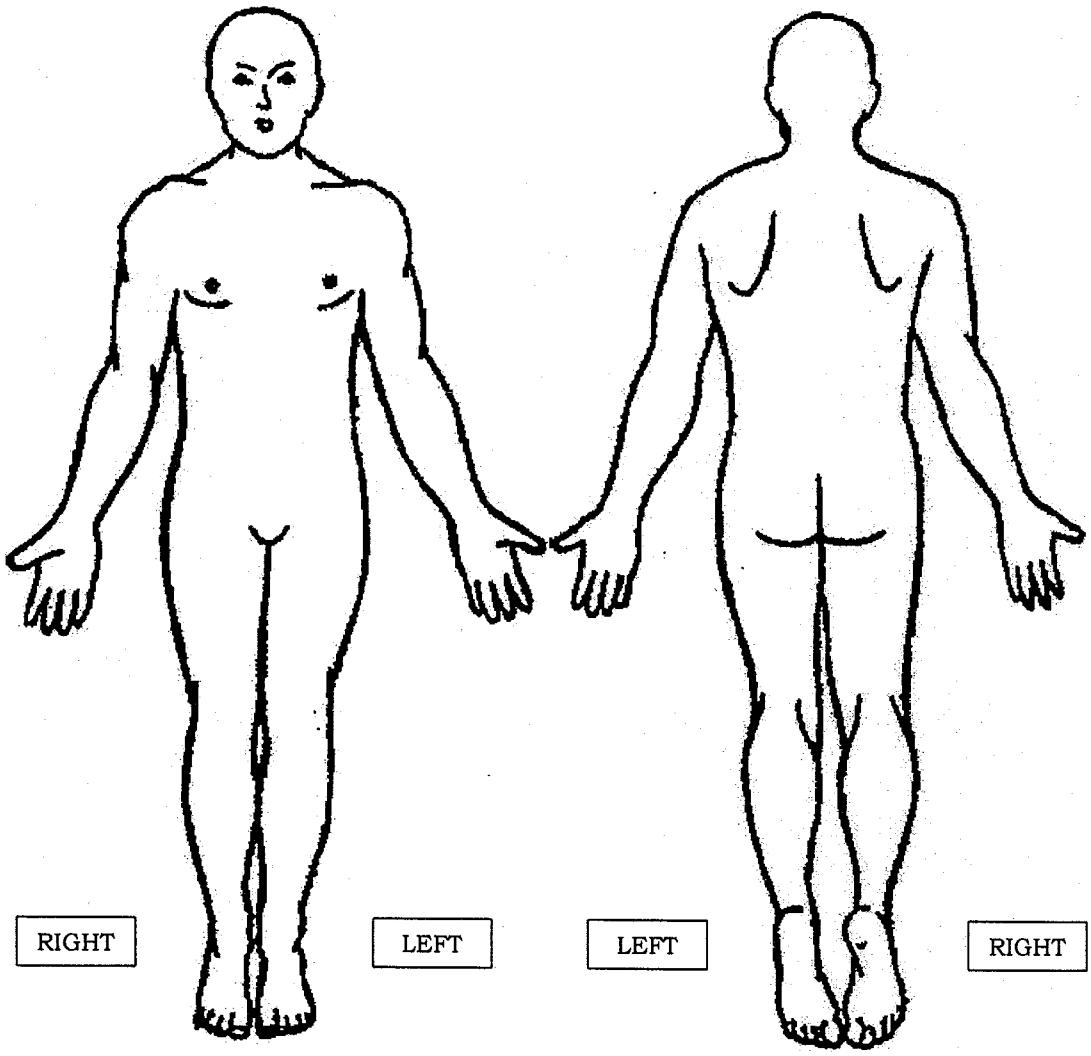
Signature **Date**

PAIN DRAWING

NAME: _____ DATE: _____

PLEASE BE SURE TO FILL THIS OUT EXTREMELY ACCURATELY. MARK THE AREA ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATION(S). **USING THE APPROPRIATE SYMBOLS**, MARK AREAS OF PAIN, INCLUDE ALL AFFECTED AREAS, **AS YOU FEEL RIGHT NOW**. YOU MAY DRAW IN THE FACE AS WELL.

NUMBNESS- - - - - - -	PINS & OOOOOOO	BURNING XXXXXX	STABBING / / / /	ACHING (((((
- - - - - - - - -	NEEDLES OOOOO	PAIN XXXXXXXX	PAIN / / / / / / /	PAIN (((((((



VISUAL ANALOGUE SCALE

MAKE 1 MARK (UP & DOWN) THROUGH THE LINE, WHICH YOU THINK REPRESENTS YOUR CURRENT LEVEL OF PAIN IN YOUR MAJOR AREA OF INJURY, SOMEWHERE BETWEEN "NO PAIN AT ALL" AND "PAIN AS BAD AS IT COULD BE".

EXAMPLE (——/——)

NO PAIN AT ALL _____ PAIN AS BAD AS IT COULD BE

READ INSTRUCTIONS CAREFULLY—READ INSTRUCTIONS CAREFULLY