



SPORTS DRIVEN
REHABILITATION & TRAINING

WELCOME TO SPORTS DRIVEN REHABILITATION & TRAINING!

Thank you for choosing Sports Driven Rehabilitation & Training. For your convenience and to expedite the intake process for your visit to our clinic; please print and fill out the following forms, sign them and bring them with you to your initial evaluation.

The forms are as follows:

- 1. Patient Intake & Consent Form**
- 2. Medical History Questionnaire Form**
- 3. Medication/Pain Assessment Form**
- 4. Orientation Packet Form (Signature Only)**
- 5. Notice of Privacy Practices Form (for you to keep or return to us and we will reuse it)**

Please note that not all questions on the intake documents will pertain to everyone. Fill in all questions that pertain to you. Parents and guardians should sign for there minor children.

Be sure to bring your Referral/Prescription, ID or Driver's License and your Insurance ID card with you on your first visit.

Things to expect on your first visit:

- Your first visit will be approximately 1 hour long.**
- Please be aware of your in or out of network insurance benefits.**
- We will verify your insurance benefits and obtain authorization of your insurance benefits if required.**
- Please silence your cell phone or other electronic devices as a courtesy while in therapy.**
- Wear comfortable, loose fitting clothing with athletic or tennis shoes.**
- Please be prepared to remit any self pay, co-payment, co-insurance payment or deductible payment due at each visit.**

Thank you for taking the time to prepare the necessary forms before coming to your appointment, this will make the intake process much faster. If you have any questions, please call our office at 505-898-8300. You may also fax your documents ahead of your appointment to us at 505-898-8313.

**Sports Driven Rehabilitation & Training
4411 Montano Rd, NW, Suite F
Albuquerque, NM 87120
BeSportsDriven.com**

In the Montano Crossing Shopping Center, located west of Coors Blvd. on the north side of Montano Rd.

SPORTS DRIVEN - WEST PATIENT INTAKE AND CONSENT FORM

| | | | |
|---|--|--|---|
| Internal Use Only: | Account # <input style="width: 80%;" type="text"/> | Account Type <input style="width: 80%;" type="text"/> | Office # <input style="width: 80%;" type="text"/> |
| Last Name _____ First Name _____ MI _____ | | Date of Injury/Onset _____ Today's Date _____ | |
| E-Mail: _____ | | Date of Birth _____ Age _____ | |
| Address _____ | | Sex: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W | |
| City _____ State _____ Zip _____ | | Home Phone _____ | |
| | | Work Phone _____ | |
| Responsible Party _____ | | Cell Phone _____ | |
| Address _____ | | Injury Area _____ | |
| City _____ State _____ Zip _____ | | Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Phone Number _____ | | If Accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other | |
| Relationship to Responsible Party _____ | | Nature of Accident _____ | |
| Employer _____ | | SS# _____ | |
| Address _____ | | Occupation _____ | |
| City _____ State _____ Zip _____ | | Contact at Employer _____ | |
| Referring Physician _____ | | Phone Number _____ | |
| Primary Insurance _____ | | Insured Name _____ | |
| Group # _____ ID # _____ | | Address _____ City _____ | |
| Insured Employer _____ | | State _____ Zip _____ Phone _____ | |
| Relationship to Insured _____ | | Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Second Insurance _____ | | Insured Name _____ | |
| Group # _____ ID # _____ | | Address _____ City _____ | |
| Insured Employer _____ | | State _____ Zip _____ Phone _____ | |
| Relationship to Insured _____ | | Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Emergency Contact _____ | | Daytime Phone Number _____ | |
| Are you receiving or have you recently received home health services? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you receiving or have you recently received other therapy services? <input type="checkbox"/> Yes <input type="checkbox"/> No Please initial: _____ | | | |
| CONSENT TO TREATMENT: I consent to rehabilitation and related services at SPORTS DRIVEN-WEST. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____ | | | |
| TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____ | | | |
| LIABILITY: I know and agree that SPORTS DRIVEN-WEST is not responsible for loss or damage to personal valuables. _____ | | | |
| WAIVER AND RELEASE: I hereby release, discharge and acquit SPORTS DRIVEN-WEST, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____ | | | |
| AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to SPORTS DRIVEN-WEST and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____ | | | |
| NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____ | | | |
| I certify that all of the information provided herein is true and correct. | | | |
| Patient/Guardian Signature _____ | | Witness Signature _____ | |



SPORTS DRIVEN
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Patient Name: _____ Date of Birth: _____ Date: _____

Name of Referring Physician: _____

Date of your next Physician follow-up Appointment: _____

Date of Injury or Onset: _____ Cause of Injury or Onset: _____

Has a Doctor ever restricted your exercise or activity? Yes No

If yes, please explain: _____

Date of last physical: _____ Results: _____

Have you ever had a heart stress test? Yes No

Results of heart stress test: _____

Have you been recently hospitalized? Yes No If yes, When?: _____

Have you had prior Physical Therapy for this condition? Yes No

Have you had prior Physical Therapy this year? Yes No

Inpatient Outpatient Home Health How long? _____

Describe your general health: Excellent Good Fair Poor

Do you use tobacco? Yes No If yes, How much? _____

Do you now, or have you had any of the following Conditions? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis/HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Allergies _____ |

Do you take prescription medications? Yes No **Please List below:**

Do you have any other Medical Conditions that are not listed above? Yes No

Explain: _____

This form is accurate and complete to best of my knowledge

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MEDICATION / PAIN ASSESSMENT

Patient Name: _____ Account # _____

Diagnosis : _____ Date: _____

Verification of Medications

| Name of Medication | Dosage | Amount | How Often |
|--------------------|--------|--------|-----------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |

Over the Counter Medications (check all you take regularly)

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Aspirin/Ibuprofen | <input type="checkbox"/> Cold Medicine | <input type="checkbox"/> Laxative | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sleeping aids | <input type="checkbox"/> Allergy Relief | <input type="checkbox"/> Vitamin/Herbal supplements | |

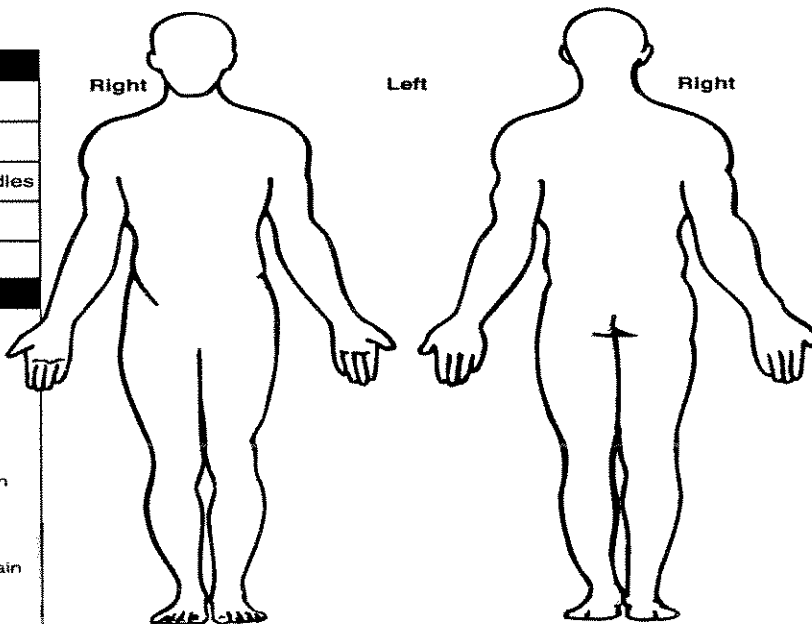
Pain Drawing

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

- RIGHT HANDED
 LEFT HANDED

| KEY | |
|-------|----------------|
| ///// | Stabbing |
| XXXX | Burning |
| 0000 | Pins & Needles |
| ===== | Numbness |
| +++++ | Aching |

| PAIN LEVEL | |
|------------|--|
| 0 | No pain |
| 1 | Mild pain; you are aware of it but it doesn't bother you |
| 2 | Moderate pain that you can tolerate without medication |
| 3 | Moderate pain that requires medication to tolerate |
| 4-5 | More severe pain; |
| 6 | Severe pain |
| 7-9 | Intensely severe pain |
| 10 | Most severe pain; |



CIRCLE YOUR CURRENT PAIN LEVEL
0 1 2 3 4 5 6 7 8 9 10

 Patient Signature

 Evaluating Therapist Name: Date

SPORTS DRIVEN REHABILITATION & TRAINING

ORIENTATION PACKET

Incident Management System

Abuse, Neglect, Misappropriation, Unknown Injury

Policy: Patients should have a quality of life that is free of abuse, neglect and exploitation. Staff shall be competent and trained to respond to, report, and document incidents in a timely and accurate manner. Consumers and guardians must be made aware of and have available accessible incident reporting processes.

Definitions:

1. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
2. Neglect means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
3. Misappropriation of property (i.e., exploitation) means the deliberate misplacement of a consumer's property, or wrongful, temporary or permanent use of a consumer's belongings or money without the consumer's consent.
4. Injuries of unknown sources means injuries for which there is no known explanation for their cause or origin.

The facility employee shall report an incident either independently or through the licensed health care facility to DHI by telephone call, written correspondence or other forms of communication utilizing the DHI incident report form.

The licensed health care facility shall report incidents utilizing the DHI incident report form, consistent with requirements of the DHI/IMB incident management system guide and CMS regulations as applicable.

The facility shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

The completed report shall be submitted to DHI/IMB within 24 hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday.

Signature: _____

First and foremost, always ensure the safety of the person, including separating the victim from the alleged perpetrator, providing needed first aid, or obtaining medical care.

For allegations of abuse, neglect, or exploitation

- ▶ DHI Fax: 1-800-584-6057
- ▶ Email to: incident.management@doh.state.nm.us
- ▶ Complete the Incident Report online at:
http://dhi.health.state.nm.us/imb/imb_irform.php

Any individual may call the HOTLINE at: 1-800-752-8649

The treating therapist and social service provider as appropriate shall document the following in the patient's medical record: The signs of abuse or neglect, action taken, physician notification, other agency referrals and client disposition, The treating therapist shall update the patient plan of care as applicable.

Notice of Privacy Practices

(Effective April 1, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record

A record is made each time you are treated at our Clinic. Your injuries, evaluation and test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. This Clinic is not required to accept your requests and you cannot request restrictions on uses or disclosures otherwise required by law. Your rights include being able to review or obtain a paper copy of your health information, and be given an account of all disclosures. You may also request communication of your health information be made by alternative means or to alternative locations in a confidential manner. This Clinic is required by law to accommodate reasonable requests to receive communications of health information by alternative means or to alternative locations if you clearly state that disclosures of all or part of the information could endanger you. This Clinic may require you to submit a written request for any of the documents or actions that you have a right to under the Health Insurance Portability and Accountability Act of 1996.

Our responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior to implementation of the new provision). In the event that changes are made, this Clinic will notify you at the current address provided in your medical file. Other than for reasons described in this notice, this Clinic agrees not to use or disclose your health information without your authorization.

Use or disclosure of your health information without your authorization

This Clinic may use and disclose your health information in order to provide "Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons as detailed below:

- **Treatment** – Information obtained by your therapist in this Clinic will be recorded in your medical record and used to determine the course of treatment. This consists of your therapist recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.

- **Payment** – Your health care information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

- **Health Care Operations** – The medical staff in this Clinic will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality

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Attachment B1.003C

Attachment M7.005A

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improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

- **Business Associates** – Some or all of your health information may be subject to disclosure through contracts for services to assist this Clinic in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this Clinic through terms detailed in a written agreement.
- **Notification** –Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.
- **Communications with Family** – Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care and/or recovery.
- **Worker's Compensation** – This Clinic will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health** – This Clinic is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This Clinic is further required by law to report communicable disease, injury, or disability.
- **Law Enforcement** – This Clinic may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court order or a grand jury or administrative subpoena.
- **Health Oversight Activities** – This Clinic may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with rules of governmental health programs, such as Medicare or Medicaid.
- **Victims of Abuse, Neglect or Domestic Violence** – If this Clinic reasonably believes you are a victim of abuse, neglect or domestic violence, it may disclose your health information to the appropriate governmental authority, authorized by law to receive reports of such abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings** – This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.
- **As required by Law** – This Clinic may use and disclose your health information when required to do so by any other law not already referred to in the preceding categories.

Use or disclosure of your health information with written authorization

Any other use or disclosure of your health information, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, except to the extent this Clinic used or disclosed your health information in reliance of your authorization.

To receive additional information or report a problem

For further explanation of this notice you may contact our Compliance Director at 1-800-580-6285. If you believe your privacy rights have been violated, you have the right to file a complaint with our Compliance Hotline at 1-800-428-8778 or with the United States Secretary of Health and Human Services with no fear of retaliation by this Clinic at 1-800-368-1019.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a hard copy and asked to acknowledge receipt.

Health Information Privacy Complaint Phone Number: 1-800-368-1019