Vermont Sports Medicine Center

5 Albert Cree Drive
Rutland, VT 05701
(802) 775-1300
(802) 773-9300 Fax

VSMC @ Manchester
Green Mountain Village Shops
4973 Main Street
Manchester Center, VT 05255
(802) 362-2836
(802) 362-2936 Fax

VSMC @ Castleton
700 Route 4A West
Suite #1
Castleton, VT 05735
(802) 265-9940
(802) 265-9941 Fax

VSMC @ Brandon
43 Center Street
Brandon, VT 05733
(802) 247-6270
(802) 247-6271 Fax

VSMC @ Killington
Killington Medical Clinic
3902 Killington Road
Killington, VT 05751
(802) 422-1230
(802) 422-1202 Fax

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________

Address: ______________________ SS #: ______________

City: ________ State: ______ Zip: ______ Home Phone: ______________

Male ____ Female ____ Married ____ Single ____ Work Phone: ______________

Date of Injury: ________ Diagnosis: ______________ Employer: ______________

Are you currently under the care of a Home Health Care (VNA) Agency? **Yes** ______ **No** ______

Have you currently had any other physical, occupational or speech therapy this calendar year? **Yes** ______ **No** ______

If minor/student: Parent Name: ______________ Address: ______________

Home Phone: ______________ Work Phone: ______________

********Please help us verify your insurance information: Is your injury/problem related to…**

Please check one: **No Accident** ______ **Work Accident** ______ **Auto Accident** ______

Primary Ins. Co.: ______________

Address: ______________

City: ________ State ______ Zip: ______

Insured: ________ DOB: ______

Relationship to Insured: ______________

Insured's Employer: ______________

ID #: ________ Group #: ________

Secondary Ins. Co.: ______________

Address: ______________

City: ________ State: ______ Zip: ______

Insured: ________ DOB: ______

Relationship to Insured: ______________

Insured's Employer: ______________

ID #: ________ Group #: ________

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Workers' Compensation Ins. Co.: ______________ Injury Date: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Employer's Name: ______________ Contact Person: ______________

Claim #: ______________ Phone #: ______________

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Auto Accident Ins. Co.: ______________ Injury Date: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Phone: ______________ Policy #: ______________ Policyholder: ______________

Name of Attorney: ______________ Phone #: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

AUTHORIZATION TO PAY BENEFITS TO VERMONT SPORTS MEDICINE CENTER

I hereby authorize payment directly to Vermont Sports Medicine Center for all medical benefits for services rendered. I understand that I am financially responsible for any and all charges NOT COVERED by my insurance as well as any remaining deductible and coinsurance. I will pay my copayments at the time of service. Any and all medical equipment prescribed by my physician or therapist, not covered by insurance, will be paid in full at the time of delivery. In the event that I do not pay for charges billed to me, I will be responsible for all costs and attorney's fees related to collecting the charges.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Vermont Sports Medicine Center to release any information acquired in the course of my examination and/or treatment to my insurance company, physician, and employer (for Workers' Compensation only).

AUTHORIZATION TO TREAT A MINOR

I hereby authorize Vermont Sports Medicine Center to render Physical Therapy to my child (under age 18) as prescribed by my Attending Physician.

PATIENT RESPONSIBILITY INFORMATION

All insurance policies are different and therefore everyone's coverage is different. It is **your** responsibility to find out how much your policy covers, both in terms of number of visits and cost. You are responsible for payment of anything insurance doesn't cover. **Co-payments are due at the time of your visit(s).**

Your recovery is a team effort between you and your therapist. Your therapist will design a program for you based on your needs. This will include home exercises and a schedule here. In order to get optimal results you will need to follow through with these. **We require at least 24 hours notice if you need to cancel your appointment and failure to do so may result in a cancellation fee of $20.00**. In addition we may discontinue treatment if you fail to show or cancel three appointments in a row.

Thank you for letting us provide rehabilitation services to you. Please feel free to provide us feedback on how things are going at any time.

I have read and understand the above.

____ ________________________

Name **Date**

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