Performance PHYSICAL THERAPY

PATIENT HISTORY

Name: _____ Occupation: _____ Age: _____ Date: ___/___/_____

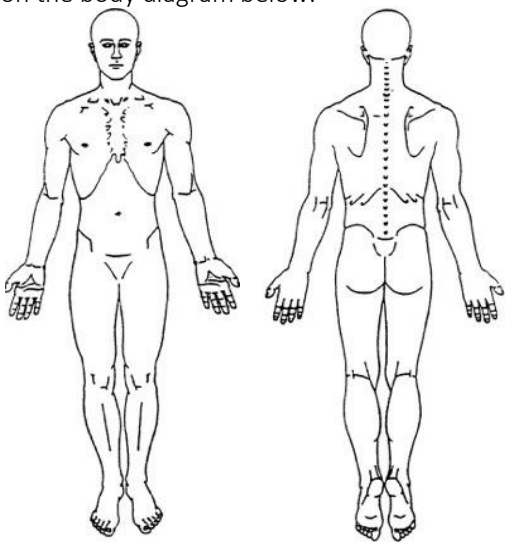
PRESENT CONDITION

Please briefly describe your symptoms. _____

_____

_____

Please localize your pain or abnormal symptoms or sensations by marking on the body diagram below.



When did you first notice symptoms? _____

Nature of symptoms (Circle all that apply):

Sharp	Dull	Throbbing	Achy
Periodic	Occasional	Constant	

How did your injury occur? (If you have had a surgery, please answer according to your pre-operative injury). _____

_____

How are your symptoms since the injury? Better Worse Same

What activities or positions aggravate your symptoms? _____

_____

What activities or positions alleviate your symptoms? _____

_____

What types of treatment have you sought for this condition?

_____

What testing have you had for this condition? _____

Test results: _____

Weekly Exercise: _____ minutes/week. Intensity: _____

Describe your typical recreational activities. _____

Since the onset of the symptoms, have you experienced any of the following (check all that apply):

- ☐ Difficulty controlling bowel or bladder function
- ☐ Fever or chills
- ☐ Numbness in the genital or anal region
- ☐ Dizziness or fainting attacks
- ☐ Unexplained weakness
- ☐ Unexplained weight change (loss or gain)
- ☐ Night pain or sweats
- ☐ Problems with vision or hearing
- ☐ None

Please list all prescription medications you are currently taking.

_____

Describe your stress level. _____

_____

What are your goals for physical therapy? _____

_____

MEDICAL HISTORY

Do you smoke? Yes No Packs per day: _____

Are you pregnant? Yes No Months: _____

Do you have any of these conditions?

Mark: 'S' for Self or 'F' for Family

___Allergies	___Lung Problems
___Arthritis	___Mental or Behavioral Disorders
___Cancer-Type: _____	
___Circulation Problems	___Multiple Sclerosis
___Depression	___Osteoporosis
___Diabetes	___Parkinson's Disease
___Epilepsy or Seizures	___Rheumatoid Arthritis
___Fibromyalgia	___Skin Diseases
___Head Injury	___Stomach Problems
___Heart Conditions	___Stroke
___High Blood Pressure	___Other: _____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge.

_____ _____

Signature Date

PATIENT INFORMATION & POLICIES

PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____

P.O. Box (if applicable): _____ City: _____ State: _____ Zip: _____

DOB: _____/_____/_____Home Phone: (_____) _____-_____Cell #: (_____) _____-_____

Email: _____

Emergency Contact: _____ Phone: (_____) _____-_____Relationship: _____

Primary Care Provider: _____ Phone: (_____) _____-_____

Referring Doctor: _____ Phone: (_____) _____-_____

How did you hear about our clinic? (Mark all the apply):

Returning Patient_____ Doctor_____ Friend_____ Internet_____ Other_____

INSURANCE INFORMATION

Primary

What is your Primary Health Insurance: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's DOB: _____/_____/_____ID#: _____ Group #: _____

Secondary

What is your Secondary Health Insurance: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's DOB: _____/_____/_____ID#: _____ Group #: _____

INCIDENT INFORMATION

Is your injury job related? (Circle one): YES NO If so, what is your Claim #: _____

Employer: _____ Claims Manager: _____ Phone: (_____) _____-_____

Billing Address For Self-Insured Companies: _____

Is Your Injury Due To a Motor Vehicle Accident? YES NO

If so, what state did it occur in? _____ Are You Covered By PIP (Personal Injury Protection Insurance)? YES NO

Auto Policy Holder: _____ Claim #: _____

PIP Adjuster: _____ Phone: (_____) _____-_____

PIP Billing Address: _____

OUR FINANCIAL POLICY

Thank you for choosing PERFORMANCE PHYSICAL THERAPY as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the physical therapist. Due to rising costs of billing by our facility, we now have the following options for payment of your bill:

WE ACCEPT cash, checks, MasterCard or Visa.

REGARDING INSURANCE

We accept assignment of insurance benefits after your first visit. Our Financial Policy requires payment in full of any balance billed to you by our facility within 30 days of receiving a statement. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 45 days, the balance may be automatically transferred to you. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for providing any/all information sent to you by your insurance company. Not returning this information will result in payment being delayed or denied, thereby becoming your responsibility.

Regarding Insurance Plans where we are a participating provider: All co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the above paragraph. In the instance that our fees go towards meeting your yearly deductible, this deductible amount will be billed to you and payable within 30 days of receipt of statement.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor or the parents (or guardians of the minor) are responsible for full payment after insurance has paid their portion. For unaccompanied minors, physical therapy will be given only with the consent and signature of our Information and Financial Policy by the parent or custodial guardian. Co-pay arrangements will stand as referenced above. It may be necessary for the minor patient to call the responsible party for Visa or MasterCard information to process his/her co-pay before receiving treatment.

MISSED APPOINTMENTS

Unless canceled, except for a genuine emergency, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per visit. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 1.5% per month for each month payment is not received. If you have a remaining balance after 60 days your account may be placed for outside collection. In the event that fees are incurred with the collection of my account, I will pay such costs and fees, including collection agency fees, attorney fees and all court costs.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read, understand and agree to the Financial Policy.

I hereby authorize my insurance company to make payment directly to Performance Physical Therapy for any benefits I may receive. I authorize the release of any information necessary to process my insurance claims, or facilitate payment of my account by a third party.

Signature of Patient or Responsible Party: _____ Date: _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We at Performance Physical Therapy keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. We will provide copies of your records to your insurance company as necessary to receive payment for our services. If you would like a copy of these records we would be happy to provide them to you at the current rate for records retrieval. You may see your records or get more information about them by contacting Performance Physical Therapy.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual: _____ Date: _____

Printed name if signed on behalf of the patient: _____ Relationship: _____

Performance
PHYSICAL THERAPY

INFORMED CONSENT FOR PHYSICAL THERAPY EVALUATION AND TREATMENT

I acknowledge and understand that I have either been referred by my physician for physical therapy evaluation and treatment of a musculoskeletal issue or I have self-referred.

I understand that to evaluate and treat my condition it may be necessary, initially and periodically, for my therapist to touch or observe parts of my body.

Treatment may include, but not be limited to, the following: heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, electrical stimulation, and educational instruction. If appropriate to my musculoskeletal diagnosis, my therapist may use manual therapy techniques, including tool assisted soft tissue mobilization and I may be asked to consent separately to this procedure.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from keeping my appointment. I agree to cooperate with and carry out any home program that may be assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

The purpose and benefits of this evaluation and treatment have been explained to me. I understand that I can terminate any procedure at any time. I understand that I am responsible for telling the therapist if I am having any discomfort or unusual symptoms during evaluation or treatment.

_____
Patient Printed Name

_____
Patient Signature