PERFORMANCE THERAPY INSTITUTE

Patient Demographics

Patient Information

Last Name _____ First Name _____ Middle Initial _____ Gender _____

Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Date of Birth _____ SS # _____ Home Phone (____)_____ Cell Phone (____)_____

E-Mail _____ Preferred Contact Method: Phone ____ E-Mail____ Text ____

Work Status _____ Employer Name (if applicable) _____ Student_____

Emergency Contact Information

Last Name _____ First Name _____ Middle Initial _____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Relationship to Patient _____

Guarantor *(complete if patient is not insurance policy holder or if patient is a minor)*

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Date of Birth _____ SS # _____ Home Phone (____)_____ Cell Phone (____)_____

Relationship to Patient _____ E-Mail _____

Accident *(complete if injury was the result of a car accident or work injury)*

Auto Insurance of Work Comp Insurance Name _____ Cell Phone (____)_____

Address _____ City _____ State _____ Zip Code _____

Policy # _____ Claim # _____ Agent / Adjuster Name _____

Date of Accident _____ Accident Location *(city and state)*_____

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General Health Questionnaire

Client Name _____ Client ID _____

Where is your current pain / problem? _____

Please rate intensity of pain: **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain *Moderate* *Pain Severe Pain*

What caused current pain / problem? _____

When did your current pain / problem start? _____

Have you ever experienced similar symptoms in the past? _____ If yes, please explain _____

_____

Are you currently having difficulty with any of the following activities? Indicate with a check mark:

_____ sitting _____ standing _____ reaching _____ dressing _____ grooming _____ housework

_____ rising _____ turning _____ lying _____ bending _____ walking _____ sleeping

_____ driving _____ stairs _____ lifting _____ athletics _____ (*other*) _____

Occupation _____ Do you consider yourself physically active at work _____

Work activities include mostly: _____ sitting _____ computer _____ standing _____ walking _____ bending

_____ lifting _____ driving _____ repetitive activity (*please explain*) _____

Past Medical History: Have you ever been diagnosed with any of the following? Indicate with a check:

_____ cancer _____ heart problems _____ high blood pressure _____ heart attack (MI)

_____ diabetes _____ thyroid problems _____ multiple sclerosis _____ rheumatoid arthritis

_____ asthma _____ tuberculosis _____ osteoarthritis _____ kidney disease

_____ hepatitis _____ stroke _____ depression _____ chemical dependency

_____ joint replacement _____ bloodborne diseases (*HIV, Aids, etc.*) _____ (other) _____

******If you answered yes to any of these please discuss with your therapist******

Please list all current medications you are taking along with dose: (you may provide list)

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

Client's (or guardian) signature _____ Date _____

Reviewed by _____ Date _____

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under contract with Performance Therapy Institute ("PTI").

I understand the nature and purposes of the procedures, evaluation and course of treatment. I understand that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

I hereby release, discharge and acquit PTI, its 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.

Financial Responsibility

I authorize my health plan to pay benefits directly. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider PTI a participating provider, charges incurred will be paid by me. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with PTI, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with PTI. We encourage you to contact your insurance company to verify your benefit information.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request (If Applicable)

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a) (1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to PTI on my behalf. I authorize PTI to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to PTI.

Guarantee of Payment (not applicable for Worker's Compensation Patients)

In consideration of services rendered to me by PTI, I agree to accept full financial responsibility for payment of charges rendered and hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with PTI become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance.

Returned Checks

We are happy to accept your personal check. However, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

Social Security Number

I have given my social security number voluntarily. PTI may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number

PTI or their agents or representatives, may contact me by telephone at any number contained in PTI's records, including wireless telephone numbers, for the purpose of servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services.

Authorization to Release Medical Information/Notice of Privacy Practices

I consent to allow PTI to use and disclose my protected health information (PHI) within PTI to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received and reviewed PTI's Consent to Physical Therapy Evaluation and Treatment, Financial Responsibility and Notice of Privacy Practices for protected health information.

Patient/relative or guardian _____ / _____
Signature Print Name

Date _____ _____
Relationship, if signed by person other than client

Documentation of Good faith Effort to Obtain Written Acknowledgment

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

____Showing the patient the Notice of Privacy Practices posted in our office.
____Giving the patient the Notice of Privacy Practices to read prior to receiving any treatment for service.
____Other (explain in detail): _____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):
____The Patient refused to sign this form.
____The Patient would not sign the form because the patient said he/she did not understand the Notice.

Date _____ Name _____