Patient Information & Medical History Form

Name: _____ Today's Date: _____

Phone #: _____ Email: _____

Occupation: _____ Date of Birth: _____

Height: _____ Weight: _____ Social Security number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Physician or Primary Family Physician: _____

Current Complaint: _____

Injury Type: _____

Date of Onset of Symptoms: _____

- Do you have a history of falling? □ Yes □ No

  If yes: Do you take medication that contributes to your falls? □ Yes □ No

- Do you have a history of your blood pressure dropping when moving from lying down to sitting up? □ Yes □ No

- Do you have visual problems that may contribute to your falls? □ Yes □ No

Have you had an MRI or x-rays that are relevant to your condition? ☐ Yes ☐ No

- **If yes**, when & where was testing done?_____
- Test Results indicated?: _____

Have you had any of the following for the condition we are seeing you for?

☐ Chiropractic Care □ Massage Therapy □ Physical Therapy □ Home Healthcare

□ Other: _____

Have you had any **surgery** that is relevant to the issue that brings you here today?

- Surgery Type: _____
- Surgery Date: _____
- Surgical Restrictions and Precautions: _____

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Patient Information & Medical History Form - page 2

Where is your pain? _____

What is your pain level? 0 = no pain, 10 = severe pain

Currently:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? _____

What makes your pain better? _____

What is difficult for you to do? _____

Functional Limitations (Check all that Apply)

☐ Walking	☐ Stairs	☐ Transferring from chair or bed
□ Running	□ Exercise	□ Reaching
□ Standing	□ Lifting	□ Bathing
□ Sitting	□ Working	□ Balance
☐ Squatting	☐ Dressing	

What job duties or activities do you perform? _____

_____

What are your goals for therapy? _____

_____

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Patient Information & Medical History Form - page 3

Medical History (Check all that apply)

- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Fibromyalgia
- ☐ Current/suspected Fracture _____
- ☐ High Blood Pressure
- ☐ Huntington's Disease
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Please list all previous surgeries and/or medical procedures:

_____

_____

_____

_____

_____

Please list all <u>current</u> medications (prescription, over-the-counter, herbals/vitamins/mineral supplements)

	<u>Medication Name</u>	**<u>Dosage</u>**	**<u>Route (oral, topical, ect.)</u>**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

By signing below, I acknowledge that the information provided above is correct.

Patient (Guardian) Signature: _____ Date_____

Patient Authorization, Release of Information & Consent for Treatment

Patient Name: _____

I am aware of my diagnosis and wish to receive treatment at Performance Physical Therapy & Wellness, LLC, hereafter, referred to as PPTW. I permit its employees and other persons caring for me to treat in ways they judge are beneficial to me. I consent to rehabilitation and related services at this Facility. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to PPTW to release information, verbal and written, contained in my medical record and other related information to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assigned and/or beneficiaries, and all other related persons as it relates to my treatment and/or payments for services provided. I authorize PPTW to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Initials _____

Assignment of Benefits

I authorize payment directly to PPTW for any Physical Therapy service provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initials _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I acknowledge that I have been given a copy of the Notice of Privacy Practices for PPTW or that I can request a copy at any time, if desired. In addition, I hereby consent to the use and disclosure of my personal health and information for the purposes of treatment, payment, and healthcare procedures.

Initials _____

Payment Guarantee

I agree to pay PPTW for the services provided to me or the party named above. If any law such as Workers' Compensation or Insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorization, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. If the information provided by the insurance company is not accurate or the insurance coverage changes, I will be responsible for payment for services. I understand that my "good-faith" payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment. Furthermore, I understand that if my balance is not paid by the payment terms set forth in the monthly statement, I will be responsible for the original balance of my account, as well as up to 30% in collection fees.

Initials _____

Patient (or Guardian) Signature: _____

Date: _____

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Physical Therapy & Wellness LLC

Policies

Coverage

As a courtesy, we check your benefits. However, **this does not guarantee payment**. You are encouraged to check your policy to verify coverage. (In addition, some treatments may require a payment for applicable **supply charges**, regardless of coverage. For example, patients receiving IDN treatment, may pay a $10 fee for needles.)

Good Faith Payment Plan

We have contractual agreements with some insurance companies and are therefore, required to collect a $ **co-pay** amount at each visit. We request patients who have a **deductible** or **co-insurance** obligation, to make payment at each appointment or at least weekly. (Any overpayment will be refunded to you.)

Cancellations & no-shows

In the event you are unable to keep your appointment, we ask that you give 24 hours notice. We reserve the right to charge $35 when 24 hours notice is not given.

For any appointment that is missed (**no-show**), you will be charged $35.

By signing below, I acknowledge that I understand the above information.

Patient (or Guardian) Signature: _____

Date: _____