PROFORMANCE
PHYSICAL THERAPY

Patient Information

Name _____ DOB ____/____/____

Address _____ City _____ State _____ Zip _____

SSN (Required**)_____Home Phone _____ Cell Phone _____

(**Because our clinic treats you before we are guaranteed of your insurance coverage, we do require your SSN as an extension of credit for our services in lieu of the alternative of billing you upfront. Your information, as always, will be kept private and secure.)

E-mail Address _____

Employer _____ Work Phone _____

Responsible Party / Insured: _____ DOB ____/____/____

Address _____ City _____ State _____ Zip _____

☐ All patient statements to be sent to this address

SSN_____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email Address _____

Emergency Contact: _____

Relationship to Patient _____ Phone Number (cell / home) _____

Circle

Health Information

Injured Area _____ **or** Reason for Visit _____

Date of Injury _____ **or** When did your symptoms begin? _____

Referring Physician _____ Primary Care Physician _____

Have you had surgery for this injury? No List **date & facility** _____

Have you had any other outpatient physical therapy this year? No

How did you hear about us? (Please Circle One)

Physician ◯ Yellow Pages ◯ Internet ◯ Past Patient/Friend ◯ Other (please list) _____

If referred by past patient/friend, whom may we thank for referring you? _____

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PLEASE CHOOSE ONE OF THE FOLLOWING PAYMENT AGREEMENTS:

Major Medical (BlueCross, United Healthcare, Coventry, Aetna, TriCare, Midlands Choice, etc)

☐ I am covered by a medical insurance plan and hereby authorize all payments on this claim go directly to Proformance Physical Therapy. I agree to pay the amount my insurance plan indicates that I am responsible for. I understand that I must first meet my deductible before my insurance will pay and that I am responsible for paying my co-pay on the day of my service if applicable.

Medicare

☐ I am a Medicare recipient and understand that Proformance Physical Therapy will file my claim to Medicare. I understand that I need a new prescription from my physician **every 60 days** and that I have a physical therapy limit of $1,950 per year. I understand that after that cap is reached I am responsible for the remaining balance. I also understand that Medicare does not pay for supplies and that I am responsible to pay at the time supplies are dispensed to me. I understand that if I do not have a supplemental insurance that I am financially responsible for the co-insurance of 20%.

Medicaid

☐ I am covered by Medicaid and I agree to produce my current Medicaid card each month for the purpose of verification of benefits by Proformance Physical Therapy. I understand that supplies are not covered by Medicaid and that if I require supplies I must purchase them from a Medicaid approved supplier. Should my Medicaid plan require a co-pay I agree to pay it at the time of my service.

Other Insurance

☐ I am covered by an insurance company that does not fit into the categories listed above. I understand that I am responsible for all charges and remaining balances that my insurance does not pay. The name of my insurance company and policy number is _____.

Self Pay

☐ I understand that payment is due at time of service unless I have signed a payment plan agreement.

**** I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read the information above and certify that this information is true and correct to the best of my knowledge.**

Signature _____ Date: _____

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Cancellation and No-Show Policy

Thank you for choosing Proformance Physical Therapy to assist you in meeting your rehabilitation needs. In order to take full advantage of your time here, it's very important that you attend all of your scheduled appointments. It is in your best interest and is the hope of your ordering physician that you are consistent with your therapy – this will result in a quicker recovery and better results.

Your therapist has set aside a specific time to work with you based on your scheduled appointment time. For this reason, **it is extremely important that you are on time for your appointment**. If you are more than 15 minutes late you will either be asked to wait until your therapist is available or be asked to reschedule for another day.

CANCELLATIONS:

We understand that the unexpected happens and you will not always be able to attend your scheduled appointment. If this is the case, please give us as much notice as possible so we can offer your appointment time to another patient. **Please cancel no less than 4 hours before your scheduled appointment.**

If multiple appointments are cancelled in succession we will assume that you are not interested in continuing therapy and you will be discharged. In addition, written correspondence will be sent to your referring physician notifying them of the situation.

NO-SHOWS:

A $25.00 fee will be charged for all patients who do not show for their scheduled appointment. As a reminder, this fee will not be billed to your insurance and is your payment responsibility. After three no-shows we will assume you are not interested in continuing therapy and you will be discharged. In addition, written correspondence will be sent to your referring physician notifying them of the situation.

IF YOU ARE COVERED BY WORKER'S COMPENSATION:

All cancellations and no-shows are noted in your chart and will be forwarded to your insurance company. Please understand that failure to actively participate in your physical therapy program may result in the impression that you are disinterested in your recovery and may have a negative effect on your worker's compensation coverage.

Signature _____ Date: _____