Date:

PROFORMANCE
PHYSICAL THERAPY

Patient Information

Name:_____ Preferred Name:_____ DOB:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

SSN (Required**)_____Home Phone:_____ Cell: _____
(**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. If under 19 years of age, the SSN is not required in this section.)
E-mail Address:_____

Employer:_____ Work Phone:_____

Responsible Party / Policy Holder

Name:_____ DOB:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____
☐All patient statements to be sent to this address

SSN:_____ Home Phone:_____ Cell:_____
(**Required if not provided above.)

Employer:_____ Work Phone:_____

Email Address:_____
**All patient statements will be sent to this email address if different from email address provided above.

Emergency Contact

Name: _____ Relationship:_____ Phone:_____

Health Information

Injured Area/Reason for Visit: _____ Injury/Symptom Date: _____

Referring Physician: _____ Primary Care Physician: _____

Have you had surgery for this injury? ☐No ☐Yes Date: _____

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

Are you currently taking any prescriptions, herbals, vitamins, or other dietary supplements? ☐No ☐Yes
If yes, please list or provide us with a copy of these medications: _____

_____

How did you hear about us?

☐Physician ☐Internet ☐Another Patient ☐Returning Patient ☐Other _____

If referred by another patient, whom may we thank for referring you? _____

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FINANCIAL RESPONSIBILITY

_____I understand my co-payment is due and payable at time of service. I understand that I am directly, completely, and fully responsible to Proformance Physical Therapy for physical therapy bills submitted for services rendered to me. Should my account become delinquent I will be responsible for additional expenses to collect on my account including reasonable legal fees, late fees, finance charges, collection costs, and other expenses reasonably incurred. I understand that any outstanding balance on my account once I have been discharged is subject to a payment plan established by Proformance Physical Therapy, which will be sent to me via email and mail should such plan become necessary.

AUTHORIZATION TO TREAT

_____I authorize Proformance Physical Therapy to render physical therapy services to myself/my child or person to whom I am a legal guardian.

CANCELLATION/NO-SHOW POLICY

_____ I understand that I am to inform Proformance Physical Therapy of my cancellation **no less than 4 hours** before my scheduled appointment and if I am more than **15 minutes** late to my appointment I will be asked to reschedule. Additionally, I understand that a **$25.00 fee** will be charged if I fail to contact Proformance Physical Therapy and miss my appointment altogether. I understand that after three no-shows or a succession of multiple cancellations it will be assumed that I am no longer interested in continuing therapy and I will be discharged. At that time, written correspondence will be sent to my referring physician notifying them of the situation.

MEANS OF PATIENT CONTACT

_____ I consent to receiving communication including texts, emails, letters, and phone calls from Proformance Physical Therapy by means of any phone number, email address, or mailing address that I have provided.

MEDICAL RELEASE OF INFORMATION

_____ I understand that my records from Proformance Physical Therapy may be released for processing claims to payers as well as to the referring physician and other healthcare providers directly related my care. All other requests for release of medical information will require my written or verbal consent unless the law authorizes or compels Proformance Physical Therapy to do so.

By my signature below, I hereby attest that I have read, understand, and agree to the above policies and that should I have questions regarding HIPAA, a current Notice of Patient Information Practices is available upon request.

Patient Name: _____

Signature: _____ Date: _____

Signature of patient or parent/guardian if under 19 years of age.