Date:

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. If under 19 years of age, the SSN is not required in this section.)

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 _____

(**Required if not provided above.)

Employer _____ Work Phone _____

Email Address _____

Emergency Contact: _____

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

Circle

Health Information

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

Referring Physician _____ Primary Care Physician _____

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

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

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

◯ Physician ◯ Internet ◯ Another Patient ◯ Returning Patient ◉ Other _____

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

PROFORMANCE
PHYSICAL THERAPY

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 and Sports Rehab, P.C. for physical therapy bills submitted for services rendered me, and that this agreement is primarily for Proformance Physical Therapy and Sports Rehab's additional protection beyond any lien being filed or financial responsibility being served and in consideration of his awaiting payment. 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.

AUTHORIZATION TO TREAT

_____ I authorize Proformance Physical Therapy and Sports Rehab, P.C. to render physical therapy services to myself/my child or person to whom I am 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. I understand that 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 understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES/INSURANCE REQUIREMENTS

The undersigned does acknowledge receipt of the Proformance Physical Therapy and Sports Rehab, P.C. HIPAA Notice of Privacy Practices for Protected Health Information as well as the receipt of requirements necessary for proper payment from each of the following payment sources: commercial insurers, Medicare, Medicaid, Tricare/VA, self-pay, worker's compensation, and personal injury insurers.

By my signature below, I hereby attest that I have read and understand the above information and have received the current Notice of Patient Information Practices and Insurance Requirements Information.

Signature: _____ Date: _____

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

Witness: _____ Date: _____

***Please note this form must be signed in office
after the receipt of Notice of Privacy Practices/Insurance Requirements****

PROFORMANCE
PHYSICAL THERAPY

Medical Release of Information

This is a HIPAA Privacy Authorization Form for the use or disclosure of protected health information for all individuals age 19 years or older. If under the age of 19, a parent/guardian can designate to whom medical records are disclosed. Medical information is released for processing claims to payers as well as to the referring physician and other healthcare providers directly related to the patient's care. All other requests for release of medical information will require patient consent unless the law authorizes or compels Proformance Physical Therapy and Sports Rehab, P.C. to do so. All medical records will be retained for up to 7 years and are accessible to the patient upon written request.

Authorization

I authorize Proformance Physical Therapy and Sports Rehab, P.C. to use and disclose the protected health information described below to the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

☐ I do not authorize the release of my medical information to any other party other than those required to process my claims and all healthcare providers associated with my care.

Effective Period

This authorization for release of information is valid for:

☐ One year following the date this form was signed.

or

☐ All past, present, and future periods.

- This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until either one year has elapsed or I revoke this authorization, in writing, whichever is indicated above.
- I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

By signing this form I authorize the release of my complete health record to the above stated person(s).

_____ Date:_____

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