New Patient Information & Medical History Form

Name: _____ Today's Date _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

What is your regular job? _____

What are your job duties (or activities you perform, if retired)?

1.

2.

How can we help you? _____

If this was a result of an injury, what happened? (If there was no injury, write "no injury")

_____

Date symptoms started? _____

Have you had any surgery that is relevant to the problem that brings you here today? If yes, what was done and when?

_____

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

If yes, when & where was testing done?

_____

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

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

What makes your pain worse?

What makes your pain better?

What is difficult for you to do?

Have you had Home Health care for the current condition we are seeing you for? ☐ Yes ☐ No

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 any unexplained weight loss recently? ☐ Yes ☐ No

How would you rate your general health?

☐ Good ☐ Fair ☐ Poor

Please list all current medications with dosage:

Prescription _____

Over-the-counter_____

Herbals/Vitamins/Mineral Supplements_____

Please list all previous surgeries:

Self-Medical History (Check all that apply)

☐ No known
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Cerebral Vascular Accident
☐ Current Infection
☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Fibromyalgia
☐ Current Fracture/ Suspected Fracture, if yes: _____
☐ High Blood Pressure
☐ History of Cancer
☐ Huntington's
☐ Immunosuppression
☐ Lupus
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Traumatic Brain Injury

What are your goals for therapy? _____

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: _____ Date of Birth: _____

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 and 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 services and to bill and release payment directly to PPTW for any Physical Therapy services 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 (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for PPTW. In addition, I hereby consent to the use and disclosure of my personal health and information for the purposes of treatment, payment, and healthcare operations.

Initials _____

Payment Guarantee

I agree to pay PPPTW 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. The *Verification of Benefits/Intake Information Form* is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. 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 treatments, unless agreed to in writing by myself and a representative of PPPTW. If my account is not resolved in a timely manner and it is turned over to collections, I understand that I will be responsible for the original principle balance of my account, as well as up to 30% in collection fees.

Initials _____

Patient (or Guardian) Signature: _____ **Social Security #** _____

Date_____

Policies

Coverage

As a courtesy, we check your benefits. However, **this does not guarantee payment**. You are encouraged to check your policy for coverage.

Good Faith Payment Plan

We have contractual agreements with some insurance companies to collect co-pays at each visit. Therefore, we request patients that have a co-insurance payment obligation, to pay a percentage of the payment at each time of service.

Cancellations

In the event you are unable to keep your appointment, we ask that you notify us at least 24 hours prior to your appointment. We reserve the right to charge $50 for any missed appointment.

Billing:

We use an outside company for our billing services and insurance claim submissions. If you have any questions or concerns regarding this, you are encouraged to contact *Collectivity*. If they are unable to help you, please contact us.

How did you hear about us?

- ☐ Friend_____
- ☐ Family_____
- ☐ Physician_____
- ☐ Newspaper_____
- ☐ Radio_____
- ☐ Facebook, Social Media, ect.
- ☐ Web Search (computer/phone)
- ☐ Other _____

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

Patient (or Guardian) Signature: _____

Date: _____