PER4MANCE Physical Therapy

PATIENT INFORMATION			EMAIL ADDRESS:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Per4mance Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Per4mance Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Do you have any of the following? Please check all applicable

Pacemaker _____ Cancer _____ Allergies _____ Heart Disease ____
Metal Implants ____ Diabetes ____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature of Patient, Parent, Guardian, Personal Representative Date

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Office Practice/Clinic personnel at this facility are hereby authorized to administer any medical or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, teeny proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by this Office Practice/Clinic and are accessible to office personnel. Office Practice/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office Practice/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that this Office Practice/Clinic advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. Office Practice/Clinic personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that therapist benefits otherwise payable to the insured are to be made payable to the therapist(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check, or credit card at the time of service.

FINANCIAL RESPONSIBILITY

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic.

NO SHOW/CANCELLATION FEE:

I understand that when an appointment has been scheduled for me, the time is reserved for my care and treatment If I am unable to make my scheduled appointment, I will call the office and give 24 hour notice prior to my appointment. A fee of $25.00 may be added to my account for missed scheduled appointments. This fee may be waived in emergency cases.

OTHER THERAPY INFORMATION:

Have you received any outpatient physical, occupational, or speech therapy services, home health services or skilled nursing facility services in the current calendar year? YES NO

If yes, please indicate which type(s) of services you received:

PT _____ OT _____ Speech _____ Home Health _____ Skilled Nursing Facility _____

When? _____

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____	_____	_____	_____
Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness

_____	_____
Patient Name (Please Print)	Account Number

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this Office Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Office Practice/Clinic.

I have received a copy of Notice of Privacy Practices.

_____	_____	_____	_____
Representative	Relationship to Patient	Date Signed	Witness