Absolute Performance THERAPY

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: Home ( )_____ Work: ( )_____ Cell: ( )_____

Preferred Way to contact you: □ **Home** □ **Cell** □ **Work** □ **Email**

Best phone number to reach you at: _____ (parent phone # if patient is a minor)

Email address: _____ Date of Birth: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed

Referring Physician: _____ Date of next visit: _____

Primary Insurance: _____

Is this insurance policy in: □ Your name □ Your spouse's name □ Parent
Spouse's DOB: _____ Parent's DOB: _____

Secondary Insurance: _____

Are you aware of your insurance benefits? □ Yes □ No Do you have questions about your insurance? □ Yes □ No

Would you like us to charge your copay/coinsurance to your credit/healthcare flex card? □ Yes □ No

Card number: _____ 3 digit code: _____ Expiration date: _____
Would you like a receipt mailed to you? □ Yes □ No

Is the pain you are experiencing a result of an accident? □ Yes □ No
If YES, What type of accident? □ Motor vehicle □ Work related □ Other
Date of accident: _____

Have you had an MRI or similar test done? If "yes" please list what test and where they were performed:
Tests: _____ Where: _____

Have you had physical therapy this calendar year? □ Yes □ No Where? _____
Was it for the same reason you are here today? □ Yes □ No

Are you currently receiving home health care? □ Yes □ No

How did you choose our clinic? □ Doctor □ Family/Friend □ Internet □ Location □ Attended one of our clinics

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Patient Financial Responsibility Policy

Patient Name: _____ DOB: _____

Patient agrees to pay for all services due in full at time that services are provided by our office.

Commercial Insurance Carriers:

- We bill insurance carriers for you if proper paperwork is provided to us. Failure to update insurance cards, change of address, or information needed to submit your claim will result in the patient being fully responsible for charges.
- Any outstanding balances, copays, and deductibles are due prior to checking in for your appointment.
- A credit card number must be left on file for any minor that will be attending an appointment without an adult.

Medicare

- Our office is a Medicare participating provider and we will bill Medicare for you. Medicare automatically submits claims onto your secondary insurance, if you have one. Any balance not paid by Medicare and your secondary insurance will be your responsibility. Medicare allows $2,010 per calendar year for physical therapy and speech therapy combined.
- You are NOT allowed to receive home health services at the same time as outpatient physical therapy. Please let us know if you have received home health care during this calendar year.

Worker's Compensation

- If your visit is work-related we will need the case number and carrier name prior to your first visit in order to correctly bill your works compensation carrier.

Cash Visit

- If you exhaust the number of visits allotted by your insurance carrier or you do not have health insurance we offer a self pay cash rate of $100 per visit.

Cancellation and No Show Policy

- Due to high demand for appointments in our office we require a 3 hour notice for cancellations. Failure to give appropriate notice or not showing up for an appointment will result in a **$100** fee. **This fee must be paid prior to scheduling or attending any further appointments.** After 2 no shows you will be dismissed from our practice and not able to schedule again.

Physical Therapy Supplies

- Health insurance does not reimburse for medical goods such as pulleys, theraband, shoe lifts, orthotics, braces, etc. The patient will be responsible for the cost of any medical goods issued to them for home use.

Returned Checks

- Returned checks are subject to a $36 fee and your account will be placed on a "cash-only" basis." We will accept payments only by cash or credit card until balance is cleared.
- Patients will not be able to schedule appointments until balance is cleared.

I have read and I understand the above financial policies for Absolute Performance Therapy, PC

Signed: _____ Date: _____

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Occupation: _____ Hobbies: _____

Date of Injury/Onset of Pain: _____

Has your pain prevented you from working? □ Yes □ No If yes how long have you been off of work? _____

Work status: At the present time I am able to:

□ Work without restrictions
□ Work the same job WITH restrictions
□ Work a different job WITH restrictions
□ Unable to work due to dysfunction
□ Homemaker
□ Retired

Have you had surgery for your current pain: □ Yes □ No

If yes, what type of surgery: _____ When did you have it done: _____

Have you previously had physical therapy? □ Yes □ No

If yes, when and where? _____

Please list all prescription medications you are taking (include recent injections and skin patches):

Medication: _____ Used for: _____

Medication: _____ Used for: _____

Medication: _____ Used for: _____

Medication: _____ Used for: _____

Please list any surgeries or conditions for which you have been hospitalized:

Surgery/Hospitalization: _____ Date: _____

Surgery/Hospitalization: _____ Date: _____

Surgery/Hospitalization: _____ Date: _____

Do you have a pacemaker? □ Yes □ No

Are you currently having or have you experienced these symptoms in the last 3 months?

□ Numbness
□ Headaches
□ Shortness of breath
□ Pins/Needles
□ Skin rash
□ Vision Problems
□ Bowel/Bladder Problems

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Please check all the following conditions that apply to you either currently or in the past:

□ High blood pressure
□ Chest pain
□ Stroke
□ Heart surgery
□ Depression
□ Attention deficit
□ Cancer (type: _____)
□ Epilepsy/Seizures
□ Heart Attack
□ Asthma
□ Emphysema
□ Concussion (How many? _____)
□ Concentration issues
□ Arthritis
□ Gout
□ Diabetes
□ Memory Issues
□ Falls
□ Migraines

At this time, does your pain limit your ability to: (Check all that apply)

□ Sleep
□ Perform self care tasks
□ Reach/Push/Pull Objects
□ Enjoy previous hobbies
□ Walk
□ Lift/Carry objects
□ Drive a car
□ Exercise
□ Work Related Tasks
□ Sit for long periods
□ Stand for long periods
□ Play sports

How would you describe your pain? (Deep, stabbing, sharp, aching, dull, shooting?) _____

On a scale of 0-10 (0 being no pain and 10 being pain that sends you the ER) how would you rate your pain?

Best: _____ Worst: _____ Current: _____

What is your goal for physical therapy?

_____

Is there anything else about your condition that we should know about?

_____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Absolute Performance Therapy, PC and it's employees to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Signature of Patient/Guardian: _____ Date: _____

Print Patient's Name: _____