PATIENT INFORMATION

First and last Name: _____, ____ (Jr., Sr., etc.) Sex: M or F
Street Address: _____ Apt. /Space: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Date of Birth: _____ Age: _____ Social Security #: _____
Divers License #: _____ State: _____ Marital Status: _____
Employer: _____ Occupation: _____
Email: _____

Primary Insurance Co: _____ Policy Holder: _____
Relation: _____ Phone #: _____ SS#: _____
DOB: _____ Group #:_____ID/Claim/Policy#:_____
Adjuster's Name/Phone#: _____

Secondary Insurance Co _____ Policy Holder: _____
Relation: _____ Phone #: _____ Insured SS#: _____
DOB: _____ Group # : _____ ID/Claim/Policy#:_____
Please indicate if there is a Tertiary Insurance Co: Y/N Info: _____

Please indicate if your injury is related to any of the following:
Motor Vehicle Accident: Y/N If yes, date of accident: _____State accident occurred in: _____
Work/Job: Y/N if yes, date of injury: _____Worker's Comp. Insurance Co. _____

Do you have an Attorney pertaining to this injury? YES/ NO, If yes
Attorney's Name: _____ Attorney's Phone: _____

Your Primary Care Physician: _____ Phone: _____

EMERGENCY CONTACT INFORMATION
Name: _____Relation: _____Phone: _____

PREVIOUS THERAPY INFORMATION
Have you received any other Therapy Services in this calendar year? YES/ NO if so where?_____
Have you received or are you currently receiving Home Health Therapy? YES/NO
If yes, please provide dates and who provided the services_____
Have you or are you currently receiving Chiropractic treatment? YES/NO
How did you hear about our clinic? _____

Patient Medical History

Name: _____ Referring Physician: _____

Date of Injury: _____ Date of next Doctors visit for this injury: _____

Have you had surgery for this injury: ___Yes ___No Date of surgery: _____

Are you currently taking any prescription or non-prescription medications? : ___Yes ___ No

Please list all medications you are currently taking, please include dosage:

_____

_____

_____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or frequent headaches	____	____
Shortness of breath/ Chest pain	____	____	Vision or hearing difficulties	____	____
Coronary artery disease or Angina	____	____	Numbness or tingling	____	____
Do you have a pacemaker?	____	____	Dizziness or fainting	____	____
High blood pressure	____	____	Bowel or bladder problems	____	____
Heart attack or Surgery	____	____	Weakness	____	____
Stroke/ TIA	____	____	Weight loss/ Energy loss	____	____
Congestive heart disease	____	____	Hernia	____	____
Blood clot/ Emboli	____	____	Varicose veins	____	____
Epilepsy/ Seizures	____	____	Allergies	____	____
Thyroid Disease or Goiter	____	____	Any pins or Metal implants	____	____
Anemia	____	____	Joint replacement surgery	____	____
Infectious diseases	____	____	Neck injury/ Surgery	____	____
Diabetes	____	____	Shoulder injury/ Surgery	____	____
Cancer or chemotherapy	____	____	Elbow/ Hand injury/ Surgery	____	____
Arthritis	____	____	Back injury/ Surgery	____	____
Osteoporosis	____	____	Knee injury/ Surgery	____	____
Gout	____	____	Leg/ Ankle/ Foot injury/ Surgery	____	____
Sleeping problems/ Difficulties	____	____	Are you pregnant?	____	____
Emotional/ Psychological problems	____	____	Do you use Tobacco?	____	____

If yes how long have you used tobacco? _____ How often do you use tobacco? _____

List any other information that would assist us in your care: _____

_____

What are your rehabilitation expectations/ goals while in this program? _____

_____

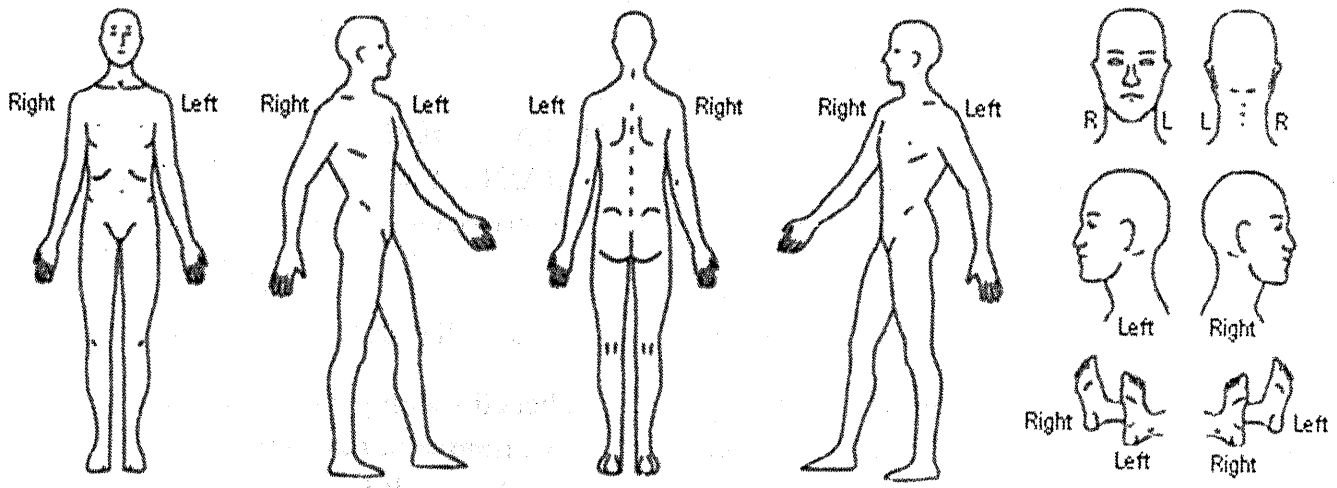
Weight _____ **Height**_____

Patient/ Guardian Signature: _____ Date: _____

iPERFORMANCE CENTER

Patient Pain Assessment

Please indicate by circling where your pain is located using the pictures below



Please use the scale below to answer the following questions

NO PAIN AT ALL 0 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

Please rate your current pain level: _____ your pain at its worst: _____ your pain at its best: _____

Please describe your pain (e.g. sharp, shooting, stabbing): _____

Please describe the frequency of your pain (e.g. constant, intermittent): _____

Please tell us what relieves your pain (e.g. rest, medication): _____

Please tell us what makes your pain worse (e.g. lifting, sitting, bending): _____

Weight _____ Height _____

_____

Patient Signature

_____

Date

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable and customary fee charged in this area by physical therapists of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **You will be expected to pay your insurance co-payment at each visit.** There will be a $25 service charge for any checks returned to our office.

There will also be a $25 charge if your appointment is not cancelled at least 24 hours in advance.

Our office will make every effort to verify eligibility and benefits with your health insurance company. **The amount quoted to us over the telephone is NOT a guarantee of payment or determination of benefits. It is an estimated amount that you are responsible for. It is ultimately your responsibility to know the type of insurance plan/policy you are enrolled in and whether or not we are contracted providers.** The exception is for those patients with work-related claims covered by Worker's Compensation. These patients are not responsible for their bills unless their claim has been denied.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to **iPerformanceCenter** for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I understand that **iPerformanceCenter** requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. I further understand and agree that if the account is not paid within 90 days of the last date of service and no financial arrangements have been made, I will be personally responsible for any and all expenses incurred in the pursuit of collection of my account including any and all attorney's fees, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue this matter and interest at the legal rate plus 2% over prime.

I also authorize **iPerformanceCenter** to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE DATE

PATIENT'S OR RESPONSIBLE PARTY'S PRINTED NAME

DATE: _____

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_____ _____

PATIENT'S OR RESPONSIBLE PARTY'S PRINTED NAME SIGNATURE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Effective date: January 1, 2015

O Yes I have read and understand the notice of Privacy Practices.

O I would like to request a copy of the Notice of Privacy Practice.

Patient Name: _____ Patient Signature: _____

HIPAA COMPLIANT AUTHORIZATION
FOR THE RELEASE OF PROTECTED
HEALTH INFORMATION

RE: (Patient Name): _____

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR sections 160 and 164.

1. The undersigned authorizes **iPerformanceCenter** to release copies of the following information: any and all medical records and billing statements including, but not limited to, notes, memoranda, correspondence, telephone call records, conclusions, diagnosis referrals, recommendations, physical therapy and rehabilitation records and notes, records or health care providers or any other written documentation relating to my treatment and/or care.

2. The information may be disclosed by employees or business associates of **iPerformanceCenter**.

3. The information may be disclosed to (**who do you want to have access to your medical records, ex: family, doctors**):

_____

_____

OR ANY OF ITS REPRESENTATIVES OR DULY AUTHORIZED AGENTS

4. The disclosure may be made for the following purpose: investigation, negotiation, litigation, conclusion and/or settlement of my bodily injury claim.

5. This authorization will remain valid until the claim settles, or otherwise concludes, through negotiation and/or litigation however, in no case will this authorization remain valid for more than three (3) years from the date signed.

6. I acknowledge:

a. that I have the right to revoke the authorization in writing sent by certified mail to **iPerformanceCenter** and;

b. I understand that once the information is disclosed, it may no longer be protected by federal privacy law; the revocation shall be effective only upon receipt, except:

I. to the extent that **iPerformanceCenter** has acted in reliance on the authorization or;

II. the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

Date: _____

PRINT NAME: _____ SIGNATURE: _____

Patient's SS#: _____ DOB: _____

If person signing is other than patient, state authority under which signature is made: _____