200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

First & Last Name: _____ Sex: Male Female

Address: _____ Apt:_____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ Age: _____

SSN: _____ Marital Status: _____

Email:_____

Primary Insurance: Company: _____

Policy Holder: _____ Relation: _____

Phone: _____ SSN: _____ DOB: _____

Group #: _____ ID/Claim/Policy #: _____

Secondary Insurance: Company:_____

Policy Holder: _____ Relation: _____

Phone: _____ SSN: _____ DOB: _____

Group #: _____ ID/Claim/Policy #: _____

Please Indicate if your injury is related to any of the following:
Motor Vehicle Accident? ☐ YES ☐ NO If yes, Date of Accident: _____ State: _____
Work/Job related? ☐ YES ☐ NO If yes, Date of Injury: _____
Workers Comp Insurance:_____
Do you have an attorney for this injury? ☐ YES ☐ NO
If yes, attorney name & phone number: _____

Name of Primary Care Physician: _____ Phone: _____

Emergency Contact: Name: _____

Phone: _____ Relation: _____

Previous Therapy Information:
Have you received other therapy services this calendar year? ☐ YES ☐ NO Where: _____
Have you received /are you currently receiving Home Health Therapy? ☐ YES ☐ NO
Have you received/ are you currently receiving chiropractic care? ☐ YES ☐ NO

200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

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 is a $25 no show/cancellation policy if your appointment is not cancelled 24 hours prior to. Please see our Cancellation & No-Show Policy for more information.

Our office will make every effort to verify eligibility and benefits with your health insurance company. It is ultimately your responsibility to know the type of insurance coverage you have and whether iPerformance Center is a in-network provider with your insurance. The exception is for those patient with work related claims covered by workers compensation. These patients are not responsible for their bills unless the claim has been denied.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to iPerformance Center for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept all financial responsibility for charges incurred whether I have insurance coverage or not. I understand that iPerformance Center requires payment in full for all services rendered at time of service, unless other arrangements have been made with the Practice Administrator. 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 all expenses incurred in the pursuit of collection of my account. This includes, but is not limited to, attorney fees, filing fees, additional charges & 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 authorize iPerformance Center 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.

Notice of Privacy Practices Acknowledgement Form

(Available online or a copy will be provided upon request)
Effective 01/01/2015

☐ YES, I have read and understand the Notice of Privacy Practices
☐ I would like to request a copy of the Notice of Privacy Practices

_____
Printed name of Patient or responsible party

_____ _____
Signature Date

200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

Cancellation & No-Show Policy

At iPerformance Center, we pride ourselves in accommodating each and every patients schedule. In our efforts to do that, we have a cancellation and no-show policy in place for all patients.

We understand that situations arise in which you must cancel your physical therapy appointment and we will work with you as much as we can. However, we ask that you provide us with 24-hour notice when possible. This will enable us to adjust the schedule and fill your appointment slot.

Cancellations made less than 24 hours before your scheduled appointment are subject to a $25 cancellation fee.

Patients who do not show up for their scheduled appointment without calling are considered a **no-show and a $25 charge** will be assessed to the patients account. Patients that no show 3 times in a 12-month period are subject to dismissal from the practice and will be denied any future appointments.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the next appointment.

We understand that unavoidable circumstances may cause you to cancel less than 24 hours before your appointment. Fees in this instance will be waived and treated on a circumstantial basis with management approval and with appropriate documentation.

Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Practice Administrator via email at Amanda@iperformancecenter.com

Please sign below stating that you have read, understand and agree to the cancellation & no-show policy.

_____
Patient Name, please print

_____ _____
Signature of patient or guardian Date

200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

HIPAA Compliant Authorization for the Release of Protected Health Information

Patient Name: _____

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

1. The undersigned authorizes iPerformance Center 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 & notes, records of 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 iPerformance Center.
3. The information may be disclosed to: (who do you want to have access to your medical records? Ex: family members, doctors, etc.)

_____
_____
_____
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 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 iPerformance Center 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 iPerformance Center 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.

Print Name: _____ Date: _____

Signature: _____

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

_____

200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

Patient Medical History

Patient Name: _____ Date: _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___
Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:
☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: _____

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea/ Vomiting	☐	☐
Bowel / Bladder Abnormalities	☐	☐			
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:	☐	☐	Stroke/CVA	☐	☐

If yes on any of the above, please briefly explain and give approximate date:
_____
_____

Is there any other information regarding your past medical history that we should know about?
_____
_____

Are you presently taking Medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition: _____
_____

200 Calusa Blvd, Suite 300 Destin, FL 32541
Office: 850.460.2024 Fax: 850.807.5365
Owned and Operated by Scott Rusin MPT, CSCS

Patient Pain Assessment

Patient Name: _____ Date: _____

How did your symptoms start? _____
_____

Briefly describe your symptoms: (example: Burning, tingling, sharp, weak, numb…)
_____
_____

Average Pain Intensity: (circle one)

Last 24 Hours - NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

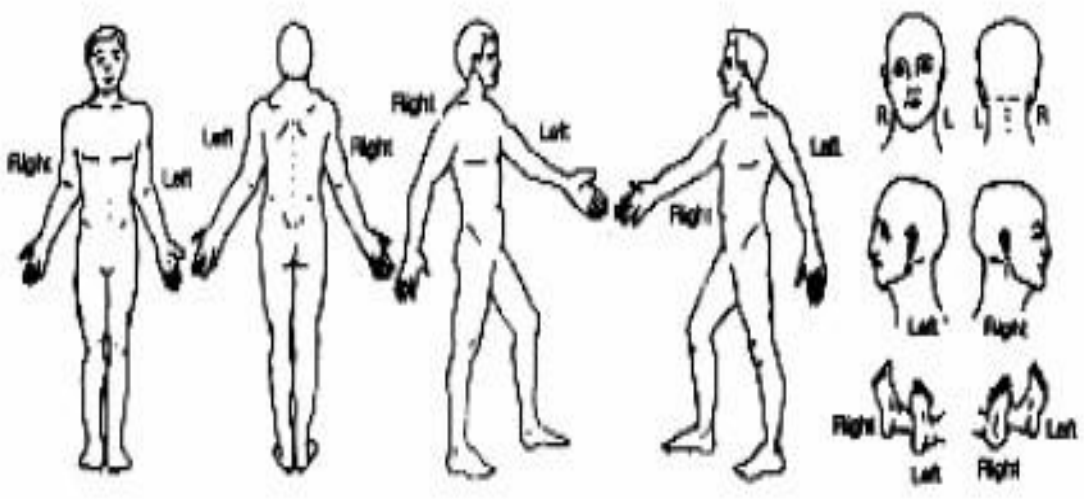
Past Week - NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

How often do you experience your symptoms: (circle one)

Constantly (76% -100% of the time) **Frequently (51% - 75% of the time)**

Occasionally (26% - 50% of the time) **Intermittently (0%- 25% of the time)**

Please indicate below where your symptoms are located:



How much have your symptoms interfered with your usual daily activities? (circle one)

Not at all **A Little Bit** **Moderately** **Quite a Bit** **Extremely**

How is your condition changing since you began at *this facility?*

NA – This is my initial visit **Much Worse** **Worse** **No Change** **Better** **Much Better**