Date:

PROFORMANCE
PHYSICAL THERAPY

Patient Information

First Name:______________________________ Last Name:___________________________________

Preferred Name:_____________________________ Date Of Birth:______/______/______

Address:___________________________ City:_______________ State:________ Zip:____________

SSN: _______________________Home Phone:____________________ Cell: ____________________

E-mail Address:____

Employer:____ Work Phone:____________________

Primary Care Physician: _________________________________ Phone:_________________________

Emergency Contact

Name: _____________________________ Relationship:_______________ Phone:________________

Responsible Party / Policy Holder – (As indicated on insurance card)

□ Responsible party is the same as patient (skip this section)

First Name:______________________ Last Name:____________________ DOB:_____/_____/______

Address:___________________________ City:_______________ State:________ Zip:____________

□ All patient statements to be sent to this address

SSN:_______________________________ Home Phone:________________ Cell:_________________

Employer:____ Work Phone:_____________________

Email Address:____

How did you hear about us?

□ Physician □ Internet □ Another Patient □ Returning Patient □ Other ___________________

If referred by another patient, whom may we thank for referring you? _______________________________

Name: ___________________________________

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Health Information

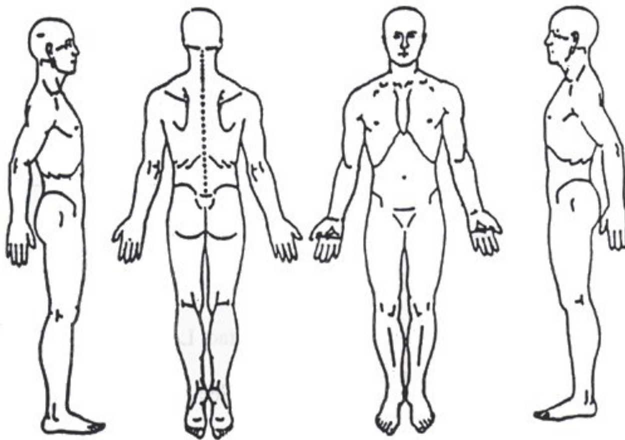
Injured Area or Reason for Visit: ____

When did your injury/symptoms begin? ____

Have you had surgery for this injury? □ No □ Yes Surgery Date: _____/_____/_____

Referring Physician: ____

Have you had other outpatient PT or chiropractic this year? □ No □ Yes



BODY CHART / PAIN CHART
(This section to be completed in clinic)

Circle the area(s) where you have symptoms.

Indicate the type of pain next to the circle

N = Numbness / Tingling
D = Dull Pain / Stiffness
S = Shooting / Sharp Pain
B = Burning Sensation

Leave circle blank of no pain involved

General Questions

Do you currently use tobacco (cigarettes, chewing, or vaping)? □ Yes □ No
Do you currently drink alcohol? □ Yes □ No
In the past 12 months, have you had a fall that has resulted in an injury? □ Yes □ No
In the past 12 months, have you fallen 2 or more times without injury? □ Yes □ No
Have you ever been diagnosed with rheumatoid arthritis? □ Yes □ No

Current Prescription Medications. You may provide us with a list to be copied.

1. __________________ Dosage __________ Frequency __________ Duration __________

2. __________________ Dosage __________ Frequency __________ Duration __________

3. __________________ Dosage __________ Frequency __________ Duration __________

4. __________________ Dosage __________ Frequency __________ Duration __________

Over-the-Counter and Herbal medications: List products that you currently use.

____

____

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FINANCIAL RESPONSIBILITY
_____I understand my co-payment is due and payable at time of service. I understand that I am directly, completely, and fully responsible to Proformance Physical Therapy for physical therapy bills submitted for services rendered to me. Should my account become delinquent I will be responsible for additional expenses to collect on my account including reasonable legal fees, late fees, finance charges, collection costs, and other expenses reasonably incurred. I understand that any outstanding balance on my account once I have been discharged is subject to a payment plan established by Proformance Physical Therapy, which will be sent to me via email and mail should such plan become necessary.

AUTHORIZATION TO TREAT
_____I authorize Proformance Physical Therapy to render physical therapy services to myself/my child or person to whom I am a legal guardian.

CANCELLATION/NO-SHOW POLICY
_____ I understand that I am to inform Proformance Physical Therapy of my cancellation **no less than 4 hours** before my scheduled appointment and if I am more than **15 minutes** late to my appointment I will be asked to reschedule. Additionally, I understand that a **$25.00 fee** will be charged if I fail to contact Proformance Physical Therapy and miss my appointment altogether. I understand that after three no-shows or a succession of multiple cancellations it will be assumed that I am no longer interested in continuing therapy and I will be discharged. At that time, written correspondence will be sent to my referring physician notifying them of the situation.

MEANS OF PATIENT CONTACT
_____ I consent to receiving communication including texts, emails, letters, and phone calls from Proformance Physical Therapy by means of any phone number, email address, or mailing address that I have provided.

MEDICAL RELEASE OF INFORMATION
_____ I understand that my records from Proformance Physical Therapy may be released for processing claims to payers as well as to the referring physician and other healthcare providers directly related my care. All other requests for release of medical information will require my written or verbal consent unless the law authorizes or compels Proformance Physical Therapy to do so.

By my signature below, I hereby attest that I have read, understand, and agree to the above policies and that should I have questions regarding HIPAA, a current Notice of Patient Information Practices is available upon request.

Patient Name: ____

Signature: ____ Date: _________________
Signature of patient or parent/guardian if under 19 years of age.