MAX PERFORMANCE
PHYSICAL THERAPY & SPORTS REHAB

New Patient Information

Full Name:_____
First Middle Last

Patient Date of Birth: _____ Current Age:_____

Nickname: _____ SSN: _____ ◯ Male ◯ Female

Street Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Employer: _____ Retired Y N Student Y N Married Y N

Email address:_____

Referring MD:_____ Family MD: _____

Date of Injury or Surgery:_____ Was injury due to: ◯ Auto Accident ◯ Work Injury ◯ Other

Have you ever had Physical Therapy? _____ If yes when _____

Are you currently receiving any home health services? Yes No
Have you had physical therapy during the current year? Yes No

Responsible Party Information: (*please complete if patient is a minor*)

Name:_____ DOB: _____ Age:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work:_____

Emergency Contact:

Name:_____Relationship:_____Phone:_____

POLICY HOLDER INFORMATION: (*Please Present Insurance Card*)

Insurance Company:_____ Insurance ID: _____

Policy Holder Name: _____ Policy Holder DOB:_____

Policy Holder Employer: _____ Policy Holder SSN: _____

Policy Holder Address *(if different from patient)*:_____

Please Circle One Answer for Each Question:

Patient Relationship to Insured: Self Spouse Child Other

How did you hear about us? Physician Friend/Relative Newspaper Website Other

MAX PERFORMANCE
PHYSICAL THERAPY & SPORTS REHAB

Patient Health Questionnaire

Patient's Name_____ **Today's Date**_____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and your referring physician give you the best possible care. Please answer every question as accurately and thoroughly as you can.

Age_____ **Height**_____ **Weight**_____ **Occupation**_____

What is your chief complaint? (diagnosis, symptoms, or condition)_____

Medical History (please check if you have any of the following:)

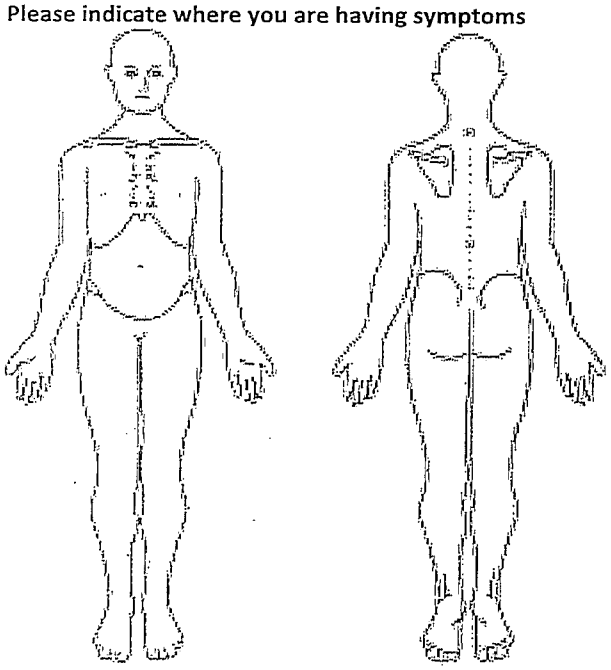
___Allergies
___Anemia
___Anxiety
___Arthritis
___Asthma
___Autoimmune Disorder
___Cancer
___Cardiac Condition
___Cardiac Pacemaker
___Drug/Alcohol Abuse
___Circulation Problems
___Currently Pregnant
___Depression
___Diabetes
___Dizzy Spells
___Emphysema/Bronchitis
___Fibromyalgia
___Fractures
___Gallbladder Problems
___Headaches
___Hearing Impairments
___Hepatitis
___High Cholesterol
___High/Low Blood Pressure
___HIV/AIDS
___Incontinence
___Kidney Problems
___Metal Implants
___MRSA
___Multiple Sclerosis
___Muscular Disease
___Osteoporosis
___Parkinson's
___Rheumatoid Arthritis
___Seizures
___Smoking
___Speech Problems
___Strokes
___Thyroid Disease
___Tuberculosis
___Vision Problems

If you checked any of the above conditions, please explain and give approximate dates and describe any other conditions not listed above:_____

_____

Is the injury due to a fall?_____ **Have you had 2 or more falls in the last year?**_____
Do you have a fear of falling?_____

Please indicate where you are having symptoms



How would you describe your pain/symptoms?

___sharp ___shooting ___aching ___dull
___numbness ___tingling ___burning
___throbbing ___other:_____

What tests have you had for this problem?

Xray_____ MRI_____ CT_____ EMG_____
Other:_____

Have you ever had surgery for this problem?(if yes, please list date of surgery)_____
Please list any other surgeries you have had:_____

_____

_____

Please check any activities you are having trouble doing due to your injury or symptoms:

___sleeping ___bed mobility ___dressing
___bathing ___sitting ___standing
___walking ___running ___bending
___housework ___computer use ___driving
___jumping ___changing direction ___lifting
___squatting ___reaching overhead ___stairs
___transfers ___reaching behind back
___sport activity:_____
___work related activity:_____
___other:_____

Please list any medications (with dosage and frequency) you are currently taking:_____

_____

_____

On a scale of 0-10, please rate your pain:

Current pain_____ worst pain_____ best pain_____
When is your pain at its worst? _____
Is it constant or intermittent? _____

MAX PERFORMANCE
PHYSICAL THERAPY & SPORTS REHAB

Release and Consent for Physical Therapy

I am attending this facility for Physical Therapy treatment and I give my consent to treatment by the attending Physical Therapist. I realize that I have the right to refuse treatment and I acknowledge that no guarantees or warranties can be made to me regarding the outcome of any treatment at this facility. I understand that any information from my medical records may be used for administrative or educational purposes; however, my identity will not be disclosed. I also understand that if I am a Worker's Compensation patient that medical records will be shared with my case manager.

I authorize Max Performance Physical Therapy to obtain or release information related to my treatment: (NOTE: INSURANCE AND REFERRING PHYSICIAN MUST BE CHECKED IN ORDER TO FILE YOUR CLAIM):

◯ Insurance Company Name: _____

◯ Referring Physician Name: _____

◯ Employer Name: _____

◯ Parent/Guardian Name: _____

◯ Spouse Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your information will be kept private and secure. Any information requested by an outside source such as an Insurance company or a doctor's office, will require proper authorization from the patient.

_____ Yes, I have been made aware of Max Performance's Privacy Policy and have been offered a copy of the HIPPA Statement

Consent to Wireless Telephone Calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify Max Performance Physical Therapy & Sports Rehab to the contrary in writing. In this section, calls, text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from Max Performance Physical Therapy & Sports Rehab, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Consent to email usage: If at any time I provide my email address at which I may be contacted, unless I notify Max Performance Physical Therapy & Sports Rehab to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from Max Performance Physical Therapy & Sports Rehab, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

_____ _____

Signature of Patient/Parent/Guardian Date

MAX PERFORMANCE
PHYSICAL THERAPY
& SPORTS REHAB

Max Performance Physical Therapy & Sports Rehab Billing Policy

I Authorize Max Performance Physical Therapy & Sports Rehab To:

- Bill my insurance company directly for the covered portion of charges and payments be made directly to Max Performance
- Release Medical information necessary to process claims.

I Understand That:

- I am ultimately responsible for my physical therapy charges and I agree to pay my deductible, co-payment or co-insurance, and any charges not reimbursed by my insurance carrier.
- Max Performance may verify my insurance benefits with my insurance carrier, however, Max Performance accepts no responsibility for incorrect information given by me or my insurance carrier regarding my benefits or plan.
- My insurance company may require medical or administrative pre-authorization for treatment or have reimbursement limits on treatment.
- I am responsible for knowing whether Max Performance is a participating provider with my insurance plan.
- **I am responsible for knowing and meeting all the requirements of my insurance plan.**
- Occasionally there may be supplies or treatments that my therapists feel are essential and necessary as part of my treatment plan and I agree to pay for these supplies and services, regardless of my insurance coverage.
- We reserve the right to apply a 1 ½ % per monthly service charge on all balances over 30 days,
- We reserve the right to place all accounts 30 days past due into collections procedures, as well as adding a fee of 35%.
- We reserve the right to apply a fee of $25.00 to the account of the patient failing to cancel an appointment 12 hours prior to appointment time. These charges are not covered by health insurance and are the responsibility of the patient/responsible party.
- There is a $35.00 fee for checks returned for insufficient funds. The patient will then be required to use cash, money order or a credit card for future transactions. After 10 days, the check will be handed over to the County Attorney's Office for collections.
- Co-payments are due at the time of service.
- If I am a Self-Pay patient, payment is due at the time of service.
- If my insurance plan is a "high deductible" plan, a treatment deposit of $100 is required at the initial appointment and a payment of $50 is required at each subsequent visit.
- I am responsible for presenting the correct insurance information and for notifying Max Performance of changes in coverage at the time of my appointment. If I provide incorrect insurance information or if I do not notify Max Performance of changes and my claim is denied as a result, I will be responsible for the charges of the claim in full.
- Max Performance does NOT file secondary claims. It will be my responsibility to file secondary insurance claims if applicable. Note: Medicare generally will forward secondary claims to supplemental plans, however, if they do not, it will be your responsibility to file with your supplemental insurance plan.

A Word Regarding Insurance:

We are happy to accept assignment of insurance benefits from your insurance carrier. As a courtesy to you we will file your primary insurance and help you estimate your insurance coverage and portion due. Your estimated portion will be due the day of service. As this will be only an estimate it may be necessary to make additional payment or be issued a refund after we have received final determination from your insurance carrier. Please note that it is your Insurance who will make the final determination regarding your benefits. As stated above, we will only be filing primary insurances, and balances due are your responsibility as is filing any secondary claims that may be applicable. Also, please note that the balance on your account is your responsibility regardless of your carrier's coverage.

I_____ have read and understand my financial responsibility for all my services rendered. I am aware my insurance contract is between me and my insurance company and I will be billed by my provider for any services rendered not payable.

Signature_____ Date:_____