



Scheduled With: _____

Schedule Date & Time: _____

Recorder's Initials _____

Personal Information Form

Today's Date: _____

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____

Sex: Male / Female

SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Email address: _____

Emergency Contact: _____ Phone #: _____

Body Part Injured: _____

Have you recently had surgery for your injury? Yes / No If yes on what date? _____

Have you received PT for this condition in the past year? Yes / No If yes where? _____

Referring Physician: _____

Phone #: _____

Primary Care Physician: _____

Phone#: _____

Is your injury due to an: Automobile accident? Yes / No

 Worker's compensation accident? Yes / No

Please sign this form verifying your personal information and/or the personal information of the minor on whose behalf you are providing the information.

Print name of patient or parent/guardian: _____ Relationship to you: _____

Signature of patient or parent/guardian: _____ Date: _____

Consent to Treatment

I, the undersigned, give the staff and/or affiliates of Premier Physical Therapy & Sports Performance, LLC consent to evaluate and treat me for the condition or conditions which I am reporting today. I acknowledge that by discussing additional conditions with the staff and/or affiliates of Premier Physical Therapy & Sports Performance, LLC during the course of my treatment, I am also implying consent to treat those conditions.

I, the undersigned, understand that the information concerning my condition and treatment is confidential and will only be released upon my written consent. All management of clinical data, which may include evaluation, treatment information or photographs, may be used in publications or presentations about diagnoses or physical therapy management. No identifying information will be disclosed and use of the data will fulfill compliance with HIPPA guidelines.

Signature: _____ Date: _____

How did you hear about Premier Physical Therapy & Sports Performance? Please circle one

Print advertisement Your coach Your physician Your Chiropractor A former patient Our staff Other _____



Insurance Information Form

Patient name: _____

Name of person on insurance policy: _____ Relationship to patient: _____

DOB: _____ SSN: _____

Patient Employer: _____ Phone Number: _____

Guarantor Employer: _____ Phone Number: _____

Primary Health Insurance Information

Name of primary insurance company: _____

Policy or ID#: _____ Group or account #: _____

Effective date of policy: _____ Insurance company phone #: _____

Secondary Health Insurance Information

Name of secondary insurance company: _____

Policy or ID#: _____ Group or account #: _____

Effective date of policy: _____ Insurance company phone #: _____

Automobile Insurance Information

Name of insurance company: _____

Claim#: _____ Adjuster Name: _____

Adjuster phone #: _____ Adjuster fax #: _____

Date of Accident: _____

Worker's Compensation Information

Name of insurance company: _____

Claim#: _____ Adjuster Name: _____

Adjuster phone #: _____ Adjuster fax #: _____

Date of accident: _____

Other Notes:



HEALTH HISTORY

Patient Name: _____ Today's Date: _____

Have you ever had these symptoms before (circle): Yes / No - If yes, when: _____

Date of Injury/onset: _____

The following Is a list of common health problems. In the first column please Indicate If you currently or have ever had any of the problems In the past. In the second column please Indicate If you are currently receiving treatment for the problem. In the last, please Indicate If the problem currently limits any of your daily activities.

	Do you or have you had the problem?		Do you currently receive treatment for this problem?		Does this problem limit your daily activities?	
	Yes	No	Yes	No	Yes	No
Heart Disease/Heart Attack	Yes	No	Yes	No	Yes	No
High or Low Blood Pressure	Yes	No	Yes	No	Yes	No
Lung Disease or Asthma	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No
Ulcer or Stomach Disease	Yes	No	Yes	No	Yes	No
Nausea or Vomiting	Yes	No	Yes	No	Yes	No
Hernia	Yes	No	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Yes	No
Liver or Gall Bladder Problems	Yes	No	Yes	No	Yes	No
Drug or Alcohol Abuse	Yes	No	Yes	No	Yes	No
Bipolar Disorder	Yes	No	Yes	No	Yes	No
Anemia or Blood Condition	Yes	No	Yes	No	Yes	No
Ringing in the Ears	Yes	No	Yes	No	Yes	No
Autism Spectrum Disorder	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Sexual Dysfunction	Yes	No	Yes	No	Yes	No
Anxiety or Depression	Yes	No	Yes	No	Yes	No
Seizures	Yes	No	Yes	No	Yes	No
Fainting Spells	Yes	No	Yes	No	Yes	No
Headaches	Yes	No	Yes	No	Yes	No

Dizziness or Vertigo	Yes	No	Yes	No	Yes	No
Nerve Disease or Disorder	Yes	No	Yes	No	Yes	No
Muscle Disease or Disorder	Yes	No	Yes	No	Yes	No
Auto Immune Disease	Yes	No	Yes	No	Yes	No
Hearing Loss	Yes	No	Yes	No	Yes	No
Vision Loss	Yes	No	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Yes	No
Communication Problems	Yes	No	Yes	No	Yes	No
Allergies	Yes	No	Yes	No	Yes	No
Skin Disorders	Yes	No	Yes	No	Yes	No
Are you Pregnant?	Yes	No	Yes	No	Yes	No
Smoking/Tabacco Use	Yes	No	Yes	No	Yes	No
Bowel or Bladder Irregularities	Yes	No	Yes	No	Yes	No
Menstrual Irregularities	Yes	No	Yes	No	Yes	No
Recent Unexplained Weight Gain or Loss	Yes	No	Yes	No	Yes	No
History of Stroke	Yes	No	Yes	No	Yes	No
Osteoporosis/Osteopenia	Yes	No	Yes	No	Yes	No
Numbness or Tingling	Yes	No	Yes	No	Yes	No
Shortness of Breath	Yes	No	Yes	No	Yes	No

Surgeries with corresponding dates:

Current Medications and reasons for taking:

Signature: _____ Date: _____

Relationship to patient: _____



Benefit Assignment/ Release of Information

As a courtesy Premier Physical Therapy and Sports Performance, LLC (hereforward - PPTSP, LLC) will submit charges to your insurance company for their consideration for payment. You are ultimately responsible for any and all charges incurred as a result of the services provided to you by PPTSP, LLC. In order to secure payment from your insurance company, you must assign your medical benefits to PPTSP, LLC. By signing below you are indicating that you are assigning your benefits to PPTSP, LLC.

I hereby assign all medical benefits to include major medical, Medicare and any other government sponsored programs, private insurance and any other health plans, worker’s compensation insurances, or automobile insurances, to which I am entitled, to PPTSP, LLC.

Print Patient/Guarantor

Signature Patient/Guarantor

Date

Financial Policy

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for all charges when services are rendered. Required co-pays are to be paid at the time of service. Co-insurances and amounts not covered by your insurance will be billed monthly if you comply with our payment policy outlined below. If you wish not to comply with our payment policy we will require payment of estimated co-insurance and other amounts not covered by your insurance at the time of service. Please note that all co-insurance and other amounts not covered by your insurance paid at the time of service are estimated. Your liability may be more. You are responsible for any difference between the estimated and actual amount owed. If we over-estimate the amount, we will send you a refund for any difference when all of your dates of service are paid in full.

Payment Policy

It is our policy to secure a method of payment (ie credit, debit or HSA card) for any balances on your account owed to PPTSP, LLC. You will receive a monthly bill for your portion of the charges as a result of services provided to you. 15 days following the date on your bill, PPTSP, LLC will debit the method of payment that you provided. Failure to provide a valid method of payment will result in an additional charge of \$25.

If you wish to dispute your bill or request other payment options, you must notify PPTSP, LLC in writing. Written requests must be received within 15 days of the date on your bill.

By providing your method of payment below, you are agreeing to comply with the policies described above. If you are unable to provide a method of payment described above, please ask to speak with our staff. I have read and understand the Financial and Payment Policies as outlined above.

Patient Name/Guarantor

Date

Signature Patient/Guarantor

Mastercard () Visa () Card Number: _____ Expiration Date: _____

Printed Name as written on your card: _____

Card Billing Address: _____

Signature: _____

Date of Signature: _____



HIPAA Compliance Statement

I consent to the use or disclosure of my protected health information by Premier Physical Therapy & Sports Performance, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Premier Physical Therapy & Sports Performance, LLC. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Premier Physical Therapy & Sports Performance, LLC, is not required to agree to the restrictions that I request. However, if Premier Physical Therapy & Sports Performance, LLC, agrees to a restriction that I request, the restriction is binding on Premier Physical Therapy & Sports Performance, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Premier Physical Therapy & Sports Performance, LLC, has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Premier Physical Therapy & Sports Performance, LLC Notice of Privacy Practices prior to signing this document. Premier Physical Therapy & Sports Performance, LLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Premier Physical Therapy & Sports Performance, LLC. Premier Physical Therapy & Sports Performance, LLC Notice of Privacy Practices is provided at the registration desk.

Premier Physical Therapy & Sports Performance, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices at the registration desk.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative