PRO Performance Therapy
(770) 449-5152
(866) 821-7683 Fax

Patient Intake Form

Name: _____ Date: _____

Address: _____
street city state zip

Sex: Male/Female Date of Birth: _____ SS#: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

Referring Physician _____ Phone: _____

Employment Information
Employed F/T_____ Employed P/T_____ Student F/T_____ Student P/T_____
Not Employed_____ Self Employed_____ Retired_____ Active Military_____

Employer/School: _____

Address: _____
street city state zip

Insurance Information
Insurance Company: _____ Insured's Name: _____

Insurance Policy Number: _____ Insured's Date of Birth: _____

Insurance Group Number: _____ Insurance Phone: _____

Date of injury or onset of symptoms: _____

Are you seeking treatment as a result of a work related injury? Yes No
Are you seeking treatment as a result of a car accident? Yes No
Are you involved in a lawsuit because of your injury or symptoms? Yes No

I authorize and request the above named insurance company to pay benefits for services rendered. I authorize Pro Performance Therapy to use, disclose, and release all medical information necessary to process my health insurance claims.

_____ _____
Patient Signature Date

After receiving and reading the Pro Performance Therapy Notice of Privacy Practices, please acknowledge below:

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:
DOB:

By signing below, I acknowledge that I have received the Pro Performance Therapy Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative Date

The privacy, security, and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt:

___ Home phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Cell phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Work phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Email: _____

___ Mail to home address: _____

___ Telephone and message to another person: _____

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult child or caregiver who often participates in their healthcare decisions and payment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Medical Screening Form

It is important to gather information about your medical history in order to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

The information was completed accurately and to the best of my knowledge.

Name: _____ Signature:_____Date:_____

Please check when appropriate. Have you or an immediate family member ever been told you have…

Please check if *you* or a *family* member (& whom) has had the below conditions……

Osteoarthritis?	_____	Heart Disease?	_____	Rheumatoid Arthritis?	_____
Diabetes?	_____	Stroke?	_____	Angina/Chest Pain?	_____
Cancer?	_____	Osteoporosis?	_____	High Blood Pressure?	_____
Allergies?	_____	Skin Disease/Rash?	_____	Asthma?	_____
Broken Bones/Fracture?	_____	Blood Disorder?	_____	Lung Problems?	_____
Circulation/Vascular Issues?	_____	Muscular Dystrophy?	_____	Head Injury?	_____
Low/High Blood Sugar?	_____	Thyroid Problems?	_____	Depression?	_____
Multiple Sclerosis?	_____	Kidney Problems?	_____	Addiction?	_____
Seizures/Epilepsy?	_____	Neurologic Disorder?	_____	STD?	_____
Ulcers/Stomach Problems?	_____	Infectious Disease?	_____	Liver Problems?	_____

In the past 6 months, have you experienced…

An overall health change?	_____	Chest Pain/Angina?	_____	Cough?	_____
Shortness of Breath?	_____	Dizziness/Fainting?	_____	Weakness?	_____
Coordination Problems?	_____	Balance Problems?	_____	Fatigue?	_____
Fever/Chills/Night Sweats?	_____	Nausea or Vomiting?	_____	Headaches?	_____
Numbness or Tingling?	_____	Trouble Sleeping?	_____	Hearing Issues?	_____
Change in Bowel or Bladder?	_____	Weight Loss or Gain?	_____	Vision Problems?	_____

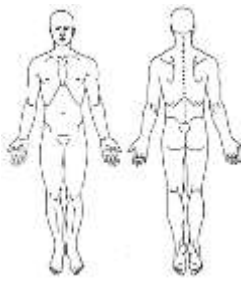
Are you currently… Under Stress? _____ Depressed? _____ Pregnant? _____

Illnesses that you have had in the past year: _____
Previous Surgeries (Please include dates): _____
Current Medications/Vitamins/Supplements: _____
Date of Last Physical and Name of Physician: _____

Do you drink alcohol? ___ How many drinks do you generally have per week? _____ Quit Date: _____
Have you ever smoked? ___ How many packs per day and for how long? _____ Quit Date: _____
Do you exercise? ___ How often? _____ Which activities? _____

What are you being seen for today? _____
How long has this been affecting you? _____ Is your condition improving ___ same___ worse ___
When do you feel the best? _____ worst? _____
What are your goals/What would you like to be able to do? _____
Please list/describe anything else that you feel is important or relevant: _____

Fill in the area of concern



Scale: 0 is no pain and 10 is worse pain
Pain at worse _____
Pain at rest_____

Functional Activities:

Please circle the activities listed below that you perform with difficulty or discomfort as a result of your injury.

Kneeling	Sleeping	Balance	Feeling	Stairs	Squatting	Bending	Walking
Pulling	Carrying	Pushing	Standing	Grasping	Reaching	Crawling	Handling
Sitting	Working	Reading	Computer	Lifting	Cough/Sneeze		

Grooming/Activities of Daily Living/Housework:

Brushing Teeth	Pulling on Shirt	Shoes/Socks	Using Toilet	Bathing	Shaving
Driving	Trousers/Pants	Lifting	Vacuuming	Laundry	Cleaning Tub
Making beds	Washing Dishes	Cooking	Sweeping	Scrubbing Floor	Mopping
Grocery Shopping	Sex				

Recreational Activities:
Jogging Hiking Bicycling Walking Golfing Skiing Aerobics Swimming Movies
Socialize with friends

FINANCIAL POLICY: Please read and initial below.

Our Financial Policy is designed to promote due diligence and provide a proactive rather than reactive strategy. With your participation, this policy will minimize and potentially eliminate errors and miscommunication with regard to your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to; deductible, co-insurance, co-payments, covered services, pre-authorization, and usual and customary charges.

_____ **REVIEW YOUR BENEFITS**

We urge you to review your insurance policy. Your insurance policy is a contract between you and your insurance company. Please call your insurance company with any specific questions about your policy relating to outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitation, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will verify your coverage, but we will not guarantee the accuracy of the information we receive. You are responsible to know your level of coverage and you are ultimately responsible for the full payment. If you have **secondary insurance** you must present it at your initial visit. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

_____ **IN-NETWORK**

You are responsible for meeting the in-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for the co-payment/coinsurance as specified in your "schedule of benefits". Pro Performance Therapy has agreed with your insurance company to accept the in network or preferred provider maximum allowable charge as full payment for the services rendered. There will be no balance billing for covered services. You are responsible to pay for any services or supplies that are received but not covered under your policy. Co-pays or deductibles are due at the time of service.

_____ **OUT-OF-NETWORK**

Pro Performance Therapy may be of network with your insurance and Pro Performance Therapy will notify you of our network participation. If your policy has out of network benefits available, we will accept your insurance, and work with you on deductibles, coinsurance, and limitations. The common insurance companies we see that we are out of network for are: BCBS POS, Cigna, and First Health. You are still responsible for meeting patient responsibility or upholding the agreement made between you and Pro Performance Therapy. You will still be responsible for deductible, co-payments and/or coinsurance at each time of service. Your out-of-network benefits for outpatient physical therapy will be clearly explained in your insurance policy's "schedule of benefits". We will submit claims for payment to your insurance company.

_____ **NON-INSURANCE CASH PLANS (Self-Pay)**

Cash plans are exclusively a non-insurance financial agreement. Cash arrangements are exclusively separate from the In-Network and Out-Network scenarios. Cash plan receipts cannot be submitted to insurance for reimbursement. Pro Performance Therapy offers a cash plan based on an insurance fee schedule and is for patients who have exhausted benefits during treatment, and those who wish to participate in therapist supervised injury prevention programs. Payment must be received for the services at the time of service, in full.

_____ **MOTOR VEHICLE ACCIDENT AND WORKER'S COMPENSATION PATIENTS**

Pro Performance Therapy does not accept third party payments. In the event you are seeking treatment for injuries sustained in a car accident, you must either use and exhaust your medical payments coverage (if applicable) or use your primary health insurance. If neither of these applies to you, we require that you obtain an attorney to ensure your claims are paid. Worker's Compensation claims should be filed and approved by your employer/worker's compensation insurance carrier BEFORE you receive services from Pro Performance Therapy.

_____ **MINORS**

A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, the parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

_____ **PAYMENT**

We accept cash, check, and all major credit cards. There will be a $25 service charge for all your returned checks. If you have insurance, balances will be considered current from the date you receive service. Patients will receive a statement every 30 days if applicable. Please ask us if you need to set-up a customized payment plan.

_____ **COLLECTIONS**

We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to our attorney for collections or further legal action. You are responsible for the unpaid balance and an additional 33% financial charge based on your unpaid balance.

_____ **APPOINTMENT POLICY**

Pro Performance Therapy understands that many of our patients have very busy schedules. Our schedule is very flexible to accommodate our patient's needs. We do understand that situations do occur that we cannot control or plan for. If you do need to cancel your appointment please give a minimum of 12 hour notice. A cancellation fee of $25.00 will apply to the 2nd cancellation without a 12 hours' notice. You must notify our office of a cancellation of your appointment by phone or email or your missed appointment will be considered a NO SHOW. Each appointment that is marked as a no show will be subject to a $25.00 charge on the first offense. A patient's refusal to initial does not exempt them from this policy. This policy applies to every patient that is seen at Pro Performance Therapy. This charge is not covered by Workman's Compensation or by insurance companies. It will be the responsibility of the patient to pay this charge.

Thank you for giving us the opportunity to serve you, and please feel free to ask us any questions concerning our services, policies and fees.

The undersigned accepts ultimate financial responsibility for services rendered.

Responsible Party Signature_____Date_____