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

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 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?	_____

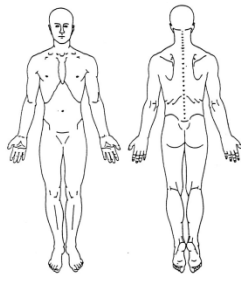
Are you currently… Under Stress? _____ Depressed? _____ Pregnant? _____

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 about 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.

As a courtesy, we will verify your coverage, but we cannot guarantee the accuracy of the information we receive. We will bill your insurance on your behalf, however, you are ultimately responsible for the payment of your bill. It is your responsibility to know your level of coverage. You are responsible for payment of any co-payment at the time of service for any co pay, deductible, and coinsurance as determined by your contract with your insurance carrier, or any cash based services provided by Pro Performance Therapy. If you have secondary insurance, you must present this information on your initial visit. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and/or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. A fee of $25 is charged to a patient's account for any returned checks. Patients will receive a statement every 30 days, if applicable. Payments can be made at each of our offices, mailed to the address on your statement, or by calling our billing department at (770) 449-5152. You may also may access our on-line bill payment option after you receive a statement. If you do have any concerns paying your bills, please ask us if you need to set-up a customized payment plan.

I have read the above policy regarding my financial responsibility to Pro Performance Therapy for providing rehabilitative services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pro Performance Therapy. I agree to pay Pro Performance Therapy the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Responsible Party Signature_____Date_____

CANCELLATION/NO SHOW POLICY

Pro Performance Therapy schedules patients to provide the highest level of quality care, while attempting to accommodate our patient's schedules at their convenience. By providing a reserved appointment time, we can minimize your wait time and assure continuity of your treatment. We understand that emergencies and other scheduling conflicts arise and are sometimes unavoidable. While we are sensitive to circumstances, chronic cancellations and no shows prevent us from accommodating other patients, as well as affecting your care.

Pro Performance Therapy requires at least a 12 hours' notice for cancellations. Patients who do not give 12 hours' notice will be responsible for a $35.00 charge. You can notify our office of a cancellation by phone or email. Each appointment that is a NO SHOW will be subject to a charge on the first offense. This charge is not covered by Workers' Compensation, health insurance, or a third-party payer. It will be the responsibility of the patient to pay this charge.

After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. This will require you to call for an open appointment on the day you would like to receive treatment. We will do everything possible to accommodate you, as the space on our schedule permits.

Please note that your attendance is recorded in your medical record and is available for your physician or third party payer to view. A patient's refusal to initial does not exempt them from this policy.

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.

Responsible Party Signature_____Date_____