PhysioHealth
PHYSICAL THERAPY

# New Patient Forms

## Demographics:

Name: ________________________________ DOB: _________ Today's Date: _________
Email: ____________________________________ May We Email You Information: Yes / No
Address (Street/City/State/Zip): _____________________________________________________
Preferred Phone Number: ____________________________ (Circle: Home Cell Work)
Secondary Phone Number: ___________________________ (Circle: Home Cell Work)

May we leave a voice message at the above numbers?: Yes / No
May we leave a text message at the above numbers?: Yes / No

Age: ______ Height: _______ Weight:_____ Sex: ________ Handedness: Right / Left
Occupation/Employer: __________________________ Are you currently off work: Yes / No

Primary Care Physician: _____________________________________

Referred By: ________________________________________________

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## Insurance Information:

Primary -
Insurance Company Name: ___________________________________________________
Subscriber Name and DOB: __________________________________________________
ID Number: ________________________________
Group Number: ____________________________
Type of Insurance (Circle One): HMO PPO Medicare Medicaid Other:_______________

Secondary -
Insurance Company Name: ___________________________________________________
Subscriber Name and DOB: __________________________________________________
ID Number: ________________________________
Group Number: ____________________________
Type of Insurance (Circle One): HMO PPO Medicare Medicaid Other:_______________

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## Reason for Evaluation:

Chief Complaint/Location of Injury: ____________________________________________
Date/Place of Injury: __________________ Date of Surgery/Type: ____________________
Auto-Accident: Yes / No - Workers' Comp: Yes / No - Legal: Yes / No

Diagnostic studies for your current condition: (X-ray, MRI, EMG, etc): _________________
Rate your pain (Average of last 72 hours): None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst
Describe your pain: Dull/Ache - Sharp/Stabbing - Pins/Needles - Shooting/Burning - Throbbing - Twinge - Numbness/Tingling - Other: ______________________
Is your pain constant: Yes / No - Intermittent: Yes / No

Aggravating Factors: ________________________________________
Relieving Factors: __________________________________________
What time of day are your symptoms Worse: __________ Best: ___________
Is your condition: Getting better - Staying the same - Getting worse

Are you currently receiving therapy: _____________________________
Have you had Therapy (PT/OT) in the last year: ___________________________
Are you currently receiving any home health care services: ____________________
If Yes to any of the above please explain: ____________________________________________

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## Medical History (Check all that apply)

- ❏ Allergies
- ❏ Anemia
- ❏ Anxiety
- ❏ Arthritis
- ❏ Asthma
- ❏ Blood Pressure (High/Low)
- ❏ Bruising
- ❏ Cancer/Tumor
- ❏ Cardiac Condition
- ❏ Cholesterol (High/Low)
- ❏ Concussion
- ❏ Cough
- ❏ Depression
- ❏ Diabetes
- ❏ DVT/Blood Clot
- ❏ Falls
- ❏ Fractures
- ❏ Fainting/Dizzy
- ❏ Headache
- ❏ Hearing Loss
- ❏ Heart Attack
- ❏ Heart Disease
- ❏ Hepatitis
- ❏ Hernia
- ❏ HIV/AIDS
- ❏ Infection
- ❏ Kidney Conditions
- ❏ Metal Implants
- ❏ Osteopenia
- ❏ Osteoporosis
- ❏ Pacemaker
- ❏ Pregnant
- ❏ Seizure/Epilepsy
- ❏ Sensitivity Heat/Cold
- ❏ Shortness of Breath
- ❏ Stroke
- ❏ Substance Abuse
- ❏ Thyroid Condition
- ❏ Tuberculosis
- ❏ Urinary Condition
- ❏ Vascular Condition
- ❏ Vision Loss
- ❏ Other: ________

If yes to any of the above, please list and explain:
____________________________________________________________

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**Past Surgical History? Yes / No**
If yes, please list w/ dates:

1. ________________________________ Date: __________

2. ________________________________ Date: __________

**Medication History - (Circle: Yes or No) - If Yes, List all current medications**

Drug:__________ Dosage:________ Frequency:______ Route:______ Reason Taking:________

Drug:__________ Dosage:________ Frequency:______ Route:______ Reason Taking:________

Drug:__________ Dosage:________ Frequency:______ Route:______ Reason Taking:________

Allergies: Do you have any Medication Allergies? If Yes, please list and explain:
______________________________________________________________
______________________________________________________________

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**Social History:**

With whom do you live?____________________ Leisure/Hobby?__________________________
Sport/Exercise?:______________________________________________________________
Goal for Therapy: ______________________________________________________________

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**The above information I have supplied is complete and accurate to the best of my knowledge.**

______________________________ ______________
Patient Signature Date

______________________________ ______________
Patent/Guardian Signature Date

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## Cancellation Policy

**Please contact our office at least 24 hours in advance if any appointment cannot be kept. We recommend that you reschedule your appointment in order to remain on course to meet your rehabilitation goals.**

**If you are late to your appointment, circumstances may require that your appointment be shortened or rescheduled to another date and time.**

**You may be discharged from therapy if multiple (greater than two) appointments are missed without advanced notice (i.e. no-show). Depending on your insurance you may then need a new therapy prescription prior to returning to therapy. If your therapy is being covered by worker's compensation then we are required to report any missed appointments.**

**Failure to cancel or reschedule 24 hours in advance of your appointment will result in a $50.00 Fee Due Prior to Next Appointment.**

**I understand the above policies of Performance Evolution Physical Therapy, and agree to abide by these policies with my signature below:**

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Guardian Signature Date

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## Consent to Treatment & HIPPA Privacy Statement

**Medical Consent:**
The undersigned hereby authorizes providers to render to patient physical therapy and wellness services (collectively referred to as “services”) that the Provider (physical therapist) determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider’s rendition of services. The undersigned acknowledges that no guarantees have been made as to the results of assessment of treatment. Services rendered at Performance Evolution, LLC are a combination of current best practices supported by literature and expert opinion.

**Medical Records Release:**
The Patient or the guarantor of the account hereby authorizes Performance Evolution, LLC to release Patient’s medical record (including any information furnished to Provider or obtained by Provider in connection with Patient’s treatment) to any referring physician, insurance company, healthcare facility, or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to the release of records to insurance carriers for the purpose of payment of claims including worker’s compensation claims to both carrier and employer.

**Medical Insurance Benefits:**
The undersigned, hereby assigns to Provider all private medical insurance benefits (primary, secondary, and medi-gap providers) or other benefits to which Patient may be entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

**Medicare and Medicaid Authorization:**
I certify that the information given by me in applying for payment under Titles XVII and IXIX of the Social Security Act is correct and I request payment of authorized benefits to the made on my behalf. I authorize the Provider to release to the Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished

to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/or Medicaid.

**HIPPA Disclosure:**
I understand Performance Evolution, LLC will maintain my privacy as it is included in my patient rights. My information may be used for administrative, billing, and clinical purposes.

**Acknowledgement of Receipt of Privacy Practice Notice:**
By signing this form you acknowledge receipt of the Notice of Privacy Practices.

**I have read and understand the above policies:**

________________________________ ________________
Patient Signature Date

________________________________ ________________
Parent/Guardian Signature Date

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## Patient Financial Policy

### To Our Valued Patients:

At Performance Evolution Physical Therapy we are committed to providing patients with the highest level of care. If you have medical insurance, we are committed to help you receive your maximum allowable benefits. In order for us to achieve these goals we need your assistance and understanding of our payment policy. Payment for services is due at each visit. This includes any applicable deductibles, coinsurance, and copayments. At our facility we accept cash, check, and major credit cards (Visa and Mastercard).

### Please review carefully:

1. We cannot guarantee the benefits quoted are exact, and therefore you may receive a statement for additional balances due after the claim is paid by your insurer. You are responsible for all balances due as a result of this service.
2. We verify eligibility and obtain insurance benefit information as a courtesy to our patients, but there may be deductibles, plan limitations, etc that we are not aware of.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. These particular services, if any, are your responsibility.
4. PCP Authorizations: Some insurance plans require a PCP authorization/referral, it is the patient's responsibility to know this and obtain the referral from your PCP. If we do not have this on file and your insurance does not reimburse us for the visit charge then you will be responsible for the visit(s).
5. Visit Limits: Some insurance plans have a limited number of visits. It is the patient's responsibility to know if you have a limited number of visits and if any have been used. Should you go over your visits and we do not get reimbursed, you will be responsible for those visit(s).
6. Please let us know if you have received occupational, physical, or speech therapy in the past year, as some insurance plans have limits on total visits. It is the patient's responsibility to know your visits. If you should go over your visits and your insurance provider denies payment, you will be responsible for the fees.
7. If you schedule two services (PT/OT/ST/Chiropractic) on the same day at two different facilities and your insurance does not cover the services then it is your responsibility for the fees incurred at our facility.
8. Worker's Compensation: Please check with our staff to ensure all authorizations have been obtained.
9. A "Self-Pay" Option is available in the event we do not accept your insurance, your benefits are exhausted, or you do not have coverage. Please call our office and ask for more information (781-859-4189)

10. Supplies: All insurances excluding some worker's compensation plans do not reimburse for supplies. The patient in this case is responsible for all supplies.

**I have read and understand the above policies:**

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent/Guardian Signature Date