

PERFORMANCE+PLUS

PHYSICAL THERAPY

PATIENT'S DEMOGRAPHICS:

TODAY'S DATE _____

PATIENT'S FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____ SEX: MALE / FEMALE

CELL#: _____ HOME#: _____ EMAIL _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

IF PATIENT IS A MINOR, PARENT/ GUARDIAN INFORMATION REQUIRED*

FIRST & LAST NAME: _____ DATE OF BIRTH: _____ SS#: _____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME: _____ RELATION TO PATIENT: _____

CELL#: _____ ALTERNATE PHONE #: _____

EMPLOYMENT INFORMATION:

COMPANY: _____ PHONE#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION:

NAME: _____ PHONE#: _____

SPONSOR SSN#: _____ MEMBER ID: _____ GROUP#: _____

REFERRING PHYSICIAN: _____

PHONE#: _____ FAX#: _____

I HAVE READ THE INSURANCE VERIFICATION AND I UNDERSTAND THESE BENEFITS ARE NOT GUARANTEED. THE ABOVE IS AN ESTIMATE FROM MY INSURANCE COMPANY. MY CO-PAYMENTS AND % OF RESPONSIBILITY IS DUE AT THE TIME I AM TREATED. IF I OWE MORE THAN THE INSURANCE COMPANY ORIGINALLY QUOTED, I WILL BE RESPONSIBLE FOR THAT AMOUNT. IF I OVER-PAY MY BILL, I WILL BE REIMBURSED THE AMOUNT I OVERPAID ONCE I AM FINANCIALLY DISCHARGED. I HAVE RECEIVED A COPY OF THIS VERIFICATION FORM.

Patient Signature: _____ Date: _____

Practice Representative: _____ Date: _____

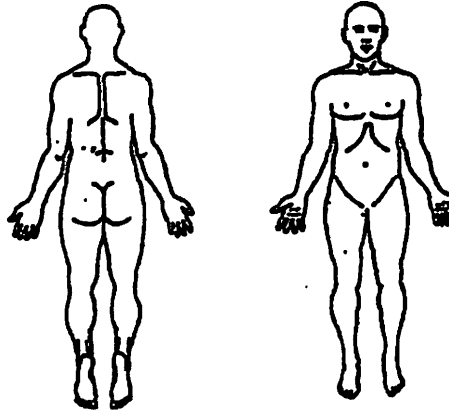
**PERFORMANCE PLUS PHYSICAL THERAPY
HEALTH HISTORY**

PATIENT NAME _____

DATE _____

WHERE IS YOUR PAIN LOCATED? (Be Specific and Label Worst Area) PATIENT TO DRAW/MARK ALL THAT APPLY

- | | | |
|-------------|----------------------------|----------------------------|
| Head | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Neck | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Upper Back | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Mid Back | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Low Back | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Shoulder | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Elbow | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Wrist | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Hand | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Buttock | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Leg (thigh) | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Knee | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Calf | L <input type="checkbox"/> | R <input type="checkbox"/> |
| Foot | L <input type="checkbox"/> | R <input type="checkbox"/> |
- LEFT**



LEFT

DATE OF INJURY _____

HOW DID YOU GET HURT? (Please give details including dates and places)

WHAT BODY PARTS DID YOU HURT? _____

HAVE YOU EVER HURT THIS BODY PART BEFORE? Yes No HOW: _____

WHO FIRST TREATED YOU, AND WHERE? _____

WHO HAS TREATED YOU SINCE? _____

CHARACTER OF YOUR PAIN PLEASE CIRCLE ALL THAT APPLY & THE LOCATION IT OCCURS:

CONTINUOUS (ALL DAY): DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUMB HOT
WHERE: _____

INTERMITTENT (ON & OFF): DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUMB HOT
WHERE: _____

OCCASIONALLY: DULL SHARP ACHING THROBBING SHOOTING RADIATING BURNING TINGLING NUMB HOT
WHERE: _____

WHAT MAKES YOUR PAIN WORSE: Sitting Standing Bending Forward or Back Walking Lying Flat Driving

How Long Can You Now: Sit _____ min. Stand _____ min. Walk _____ min. Run _____ min.

WHAT MAKES YOUR PAIN BETTER: Lying Down Walking Ice Heat PT CHIRO Massage Medications

Other _____

DOES THE PAIN LIMITS YOUR ACTIVITIES OF DAILY LIVING? YES NO

IF YES, WHAT PERCENT OF THE DAY? 10 25 50 75 100

HEALTH HISTORY FORM

What treatment have you already received for your condition?

Medications []

Surgery []

Physical Therapy []

Chiropractic Services []

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- Diabetes YES NO
- Liver Disease YES NO
- Rheumatic Fever YES NO
- Scarlet Fever YES NO
- Allergy Shots YES NO
- Epilepsy YES NO
- Migraine Headaches YES NO
- Stroke YES NO
- NO Arthritis YES NO
- Heart Disease YES NO
- Pacemaker YES NO
- Tuberculosis YES NO
- Parkinson's Disease YES NO

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alcohol	Drinks/Week_____
Daily	Light Labor	Coffee/Caffeine	Drinks Cups/Day_____
Heavy	Heavy Labor	High Stress Level	Reason_____

Are you Pregnant? YES NO Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls: _____	_____	_____
Head Injuries: _____	_____	_____
Broken Bones: _____	_____	_____
Dislocations: _____	_____	_____
Surgeries: _____	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____ Pharmacy Phone:_____		

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Performance Plus Physical Therapy to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

Performance Plus Physical Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at PPPT:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours' notice, we reserve the right to charge you a \$25.00 fee. In an instance of a no-show you will be charged a \$50.00 fee. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

Signature of Insured/Patient

Date

Practice Representative

Date

FINANCIAL POLICY

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances we may accept assignment of insurance benefits.

Deductibles and Co-payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

If you participate with our in network groups, we will bill your insurance company and accept assignment of benefits. You will be responsible for any co-pays or deductibles at each visit. We will verify your coverage and determine your out-of pocket cost prior to Treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not COMPRISE patient care based on an insurance companies "FEE SCHEDULE".
5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and Workers Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case by case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto accounts only after prior approval and a letter of protection is on file.

We must emphasize that as a Medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!

Patient's Signature/Insured

Date

Practice Representative

Date

**ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND
AUTHORIZATION FOR TREATMENT**

PATIENT: _____

1. THE UNDERSIGNED, hereby Performance Plus Physical Therapy to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy **Services**.
2. THE UNDERSIGNED hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.
5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.
6. THE UNDERSIGNED authorizes Performance Plus Physical Therapy to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against **services provided**.
7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.
8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.
9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.
10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any **interest to Provider**.
11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

Patient's Signature/Legal Representative/Insured Party

Date

Practice Representative

Date

Patient privacy rights

Health Privacy Rights

- Receive **notice** of how providers **use and share** your information with over 4 million “covered entities”, **without asking you** (“Privacy Notice” or “Notice of Privacy Policies”).
 - The right to a copy of your health records. The provider may charge a “reasonable fee” for such copies.
 - You can **request changes** to your health records. The provider does NOT have to make the changes requested. Your changes must be added to your records and the provider has to state reasons s/he disagrees with changes.
 - You can **request an accounting of disclosures** of your health information. Most disclosures do not require consent and have no audit trails. Audit trails are required only for disclosures for “no routine” uses.
 - Health establishments and “covered entities” are required to **secure information** to the best of their ability, and a **privacy official** must be designated by each “covered entity.”
 - The ADA prohibits an employer from asking about health information or requiring a physical prior to an offer if they have more than 15 employees. After the offer is made, the employer may require a medical exam if it is required by all employees with similar positions. Employers may also ask employees to authorize disclosure of their medical records. **But, if the employer is self-insured they can access their employees’ medical information without consent.**
 - **Job discrimination is the most common complaint sent in to Patient Privacy Rights.**
 - Right to **control** who can see, use, share and sell your health information.
 - Right to **feel safe talking truthfully** to your doctors.
 - Right to privacy and control of health information unless otherwise stated or required by law.
 - Right to be **notified of any breach** or possible breach of information.
 - Right to **audit trails** of every disclosure of health information. Health IT makes it easier than ever to know exactly who has your information.
 - Right to EHR and PHR systems that have the highest standards for **security (keep hackers out)**.
 - Right to participate in **research** and have researchers access your records **ONLY** if you give informed consent
 - Right to **segment sensitive information** such as mental health, addiction or STDs, in your health record.
 - Right to obtain **prescriptions** with privacy; no one should be able to use or sell your prescriptions without your consent.
- Right to obtain **employment, insurance, credit, admission to schools**, etc. without being compelled to share health information unless