New Patient Information

First Name:________________ Last Name:________________ Date:__________

SS#:______________ DOB:__________ Age:__________ Gender: ☐ Male ☐ Female

Address:____________________ City:__________ State:______ Zip:______

Phone:____________________ Email Address:____________________

Race: ☐ Caucasian ☐ Black or African American ☐ Asian Preferred Language:______________

☐ American Indian/Alaskan Native ☐ Hawaiian or Pacific Islander

☐ I decline to report

Employer:____________________ Work Phone:____________________

Work Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Temp. Disability ☐ Perm. Disability ☐ Sick Leave ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse Name:________________ DOB:__________ Phone:______________

How did you hear about us?____

If patient is a minor, please complete

Mother:________________ SS#:________________ DOB:__________

Employer:____________________ Work Phone:____________________

Father:________________ SS#:________________ DOB:__________

Employer:____________________ Work Phone:____________________

Emergency Contact Information

Name:________________ Relationship:______________ Phone:__________

Insurance Information

Primary Insurance Name:____________________ Phone:________________

Address:____

Policy Holder Name:________________ Relationship:__________ DOB:__________

Policy #:____________________Group #:____________________

Secondary Insurance Name:____________________ Phone:________________

Address:____

Policy Holder Name:________________ Relationship:__________ DOB:__________

Policy #:____________________Group #:____________________

It is to be understood and agreed that all deductibles and co-pays must be paid when the service is rendered unless prior arrangements are made with Performance Plus Rehabilitation Center. Even though an insurance claim may be filed, you are responsible for the total amount of your account, and you will receive a statement if your account has a balance due. Performance Plus Rehabilitation Center cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. I authorize the release of any medical or other information necessary to process a claim and payment of medical benefits to the treating physician.

Signature:______________________________ Date:____________________

Patient Signature (Parent Or Guardian If Patient Is A Minor)

Print Name:______________________________

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Symptom Survey

What is your chief problem or symptoms? ______________________________

What caused the problem or symptoms to occur? ______________________________

When did the problem or symptoms begin? ______________________________

Have you seen another doctor for this problem? ☐ No ☐ If yes, who: ______________________________

What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ Other________________

Have you had this problem or symptoms in the past? ☐ No ☐ If yes, explain:______________________________

Have you tried any treatment for this? ☐ No ☐ If yes, explain:______________________________

Is the problem or symptoms getting worse? ☐ No ☐ If yes, explain:______________________________

CHECK ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression / Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Headaches
☐ Cancer	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Bleeding Gums	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Chest Congestion
☐ Anemia	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma / Bronchitis	☐ Mid-Back Pain
☐ Shoulder / Elbow Pain	☐ Wrist or Hand Pain	☐ Low Back Pain	☐ Hip / Knee / Leg Pain	☐ Foot or Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea - Vomiting	☐ Irregular Bowels
☐ Eye Pain Strain				

Allergies (please list all) : ______________________________

Describe your pain (check all that apply):

☐ Constant
☐ Recurring
☐ Stabbing
☐ Dull Ache
☐ Sharp
☐ Deep Sharp
☐ Throbbing
☐ Tingling
☐ While Resting
☐ Daily
☐ During Exercise
☐ Nightly
☐ Other: ____________________

Onset of Pain:

☐ Sudden
☐ Gradual

On a scale of 1 to 10, how would you rate your pain level? ____________________ (1 = mild, 10 = intense)

What, if anything, gives you relief? ______________________________

Patient History

Do you use tobacco? ☐ No ☐ Yes, explain: ______________________________

Do you consume alcohol? ☐ No ☐ Yes, explain: ______________________________

Do you have a history of substance abuse? ☐ No ☐ Yes, explain: ______________________________

List all past surgeries: ______________________________

List all current and past medications / drugs: ______________________________

____

List all physicians you have seen in the past 5 years:

____

Primary Care Doctor: ____________________ Phone: ____________________

Are there any health problems that run in your family? ______________________________

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Auto Accident Information

First Name:________________________________ Last Name: ____________________________________ Date:______________

AUTO ACCIDENT Date: ____________________ Time: ________________________ Location: ____________________________

Were you: ☐ Driver ☐ Passenger
☐ Unconscious ☐ Treated in E.R

Wearing a Seat Belt: ☐ Yes ☐ No

Transported by Ambulance: ☐ Yes ☐ No

Fault: ☐ Self ☐ Someone Else Name of person at fault:____

Vehicle Damage: ☐ Minimal - Moderate ☐ Severe - Totaled
Was the vehicle towed away? ☐ Yes ☐ No

Police Report: ☐ No ☐ Yes with Police Department:____

Restrictions: ☐ Yes, please list_______________________________ ☐ No ☐ Missed_______________ days work or school

Accident Insurance Information

Your Med Pay Insurance Company Name:________________________________ Adjuster's Name:___________________________
Claim Number:____ Phone:___________________________________

Liable Insurance Company Name: ______________________________________ Adjuster's Name:___________________________
Claim Number:____ Phone:___________________________________

Attorney Name:____ Phone:___________________________________

Billing Agreement

LIABILITY PAYER

In personal injury cases where the liable company is at fault, we will file your claims. We can defer full payment for services rendered until settlement occurs from the liable party. Please understand that the policy to defer payment does not relieve your responsibility to pay Performance Plus Rehabilitation Center in full, nor is payment dependent on the settlement of the case. You are ultimately responsible for the settlement of your balance with Performance Plus Rehabilitation Center.

MED PAY/PIP

If there is any available Medical Payment or PIP insurance through your personal auto insurance, we will bill and receive payment directly.

HEALTH INSURANCE

If your health insurance is filed as primary insurance, you are expected to pay co-pay, deductible, and co-insurance. We will not accept amounts paid in full by the following insurance companies: United Health Care, UMR, Coventry, Golden Rule, or ASH. Performance Plus Rehabilitation Center will not submit to out-of-state plans or self-funded plans as they subrogate.

I have read and understand the agreement above and take full responsibility for the information contained. I also understand that the total cost of my medical treatment at Performance Plus Rehabilitation Center will be treated as a lien against any injury settlement. I authorize all payments to be paid directly to Performance Plus Rehabilitation Center.

Patient Signature:____ Date:___________________________

Print:____

PERFORMANCE PLUS
REHABILITATION CENTER

Health Care Privacy Notice - Informed Consent - Assignment Of Benefits - Authorization & Lien

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires doctors, therapists, staff, and patients to work together as a team to obtain maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the Notice's terms at any time without additional Notice to you, except to publicly post in our Facility and/or make available to patients on updated notices. Photocopy of this Notice is available to you upon request. The term 'Facility' refers to this office or clinic. The term 'Provider' refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify and be related to your present, future, and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings, or concerns to the Compliance Officer of this Facility.

Our Facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment, paying your health care bills and support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it causes harm to you or another person. Your provider may charge a copy fee, which will comply with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if doing so does not endanger you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed. The provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke the authorization in writing, at any time, except if the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated, and comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination, or doctor's care, a guarantee of improvement or complete recovery cannot be made, and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy, and physical therapy have some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions, and other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications. I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s), which the doctor/provider feels is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow religious beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment, your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility. I, the assignee being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to Performance Plus Rehabilitation Center against all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which the Facility has treated me. I, the assignee further authorizes any and all insurance company, attorney and all third party payer to pay directly to PPRC all sums of money due to them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any other reason of bills that are due or may become due, and to withhold such sums from any health and accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that Performance Plus Rehabilitation Center may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorize PPRC to release any information pertinent to said health care and any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants PPRC a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed to this office and assignee.

Signature:_______________________________________ Date:___________________________

Print Name:_____________________________________

Insurance Benefits - Credit Policies - Payment Terms And Conditions

As a courtesy, Performance Plus Rehabilitation Center will obtain a verification of applicable insurance benefits as they are quoted to us. However, some third party payers misquote benefits, coverage, and liability. Our Facility and staff are not responsible for what a third-party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and insurance company, liable or third party payer are between you and said person.

1. Performance Plus Rehabilitation Center will file primary and secondary insurance claims for you.
2. Co-pays, deductibles, and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and non-covered product(s) once maximum allowable has been exceeded.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed to this office, and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also owed regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 days, the patient must pay the balance in full. The assignee is fully responsible for all money owed to Performance Plus Rehabilitation Center for all treatments, products and services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, DME equipment rentals or purchases, vitamins, supplements, ointments, pillows, etc.

We accept most major credit cards, debit cards, check, cash and Care Credit.

Patient Signature:___________________________________ Date:_____________________________

Print:____

I give ______________________ access to my medical records and bills. Relationship:______________________________