PATIENT INFORMATION		EMAIL ADDRESS:_______________		
First Name:		Last Name:		Middle Initial:
Address:		City:	State:	Zip:
Birth Date: / /	Age:	Male ☐ Female ☐		SS #:
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -			Spouse:
Chose Clinic Because/ Referred to Clinic By Dr.:		Insurance Plan		Family Friend
Former Patient	Close to Work/Home	Website	Online Search	Other:

WORK INFORMATION					
Employer:				Work Phone ( ) -	Ext.
Occupation:	Employment Status:	Full Time	Part Time	Retired	Unemployed

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION

Primary Insurance Name:_______________

Subscriber's Name (If different): _______________ Birth Date:_______________

AUTO OR WORK INJURY CLAIM			
Insurance Name:	☐ Auto :	☐ Work Injury:	
Adjuster/Claim Manager:		Phone: ( ) -	Ext.:
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	
ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address:	City:	State:	Zip:
IN CASE OF EMERGENCY			
Name of Local Friend / Relative:		Name of Local Friend / Relative:	
Relationship :	Phone: ( ) -	Relationship:	Phone: ( ) -

I authorize my insurance benefits be paid directly to Performance Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Performance Physical Therapy to release any information required to process my claims.

_______________ _______________

PATIENT /GUARDIAN SIGNATURE DATE

Assignment of Benefits

I hereby guarantee payment of all charges incurred as the result of treatment received at Performance Physical Therapy including, but not limited to, insurance deductible, co insurance and other balances not paid by my insurance company. I hereby assign and direct payment of benefits under this claim directly to Performance Physical Therapy. I hereby authorize Performance Physical Therapy to provide from its medical records any and all information requested by other medical providers, insurance companies and/or attorneys in connection with the above assignments/claim. I hereby authorize Performance Physical Therapy to endorse any insurance payments/checks made payable to me with regard to services rendered by Performance Physical Therapy, I understand the financial responsibility for payment rests with me, regardless of insurance payment/benefit.

I hereby agree to pay all collection expenses of Performance Physical Therapy, including $35.00 returned check fee, attorney's fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue this matter. I understand collection fees may be assessed to the amount of the original principal balance owed. I further agree to pay an interest rate of 2 (two) percent per month, 24 (twenty-four) percent per year if account becomes delinquent.

I CERTIFY I HAVE READ AND UNDERSTAND ALL THE INFORMATION PROVIDED. I CERTIFY THE INFORMATION PROVDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

______________________________ ______________________________ ______________

Signature of Responsible Party Social Security No. Date

Medical Records

I hereby authorize Performance Physical Therapy to obtain any and all medical records requested.

______________________________ ______________

Patient Signature Date

HIPAA PRIVACY CONSENT

CONSENT

Thereby give my consent for Performance Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely. I agree that I was offered a complete copy of the policy and ☐ accepted a copy or ☐ declined a copy and referred to the notification posted on the premises.

I have the right to review the Notice of Privacy Practices prior to signing this consent and Performance Physical Therapy reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Performance Physical Therapy, 7955 W. Sahara Ave., #103, Las Vegas, NV 89117, attention: Kathy A., HIPPA Compliance Officer.

With this consent, Performance Physical Therapy may:

- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked "Personal and Confidential."
- Send unencrypted E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that Performance Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Performance Physical Therapy to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Performance Physical Therapy may decline to provide treatment to me.

______________________________	______________
Signature of PATIENT or LEGAL GARDIAN	Date

______________________________	______________________________
Print Name of Patient	Print Name of Legal Guardian, if applicable

Name:______________________________ Height:__________ Weight:__________

Medication Name	Dosage	Frequency	Method of Ingestion

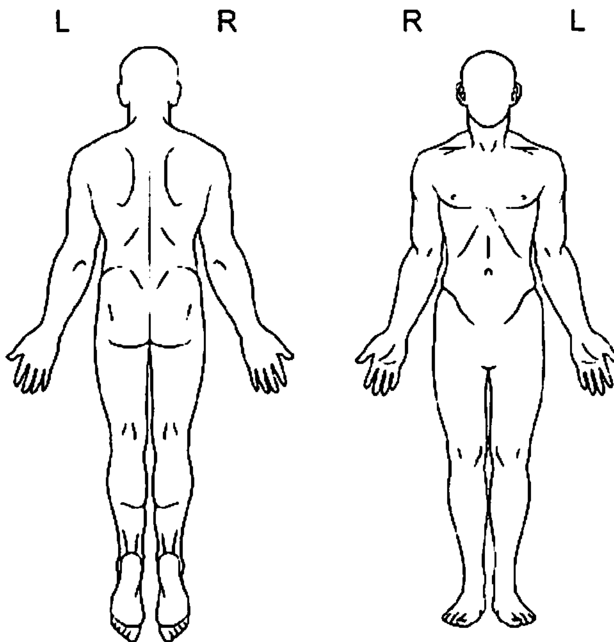
Date:______________________ PT#:______________

PERFORMANCE
PHYSICAL THERAPY

Pain and Symptom Status Report

Name: ______________________________ Date: ____________________

Mark areas of pain on body chart.



Circle any symptoms you are experiencing:

Achiness Burning Numbness

Pins and Needles Stabbing

Other: ______________________________

____

____

Chief complaint: ____

____

On a scale of 0 -10 list your **CURRENT** level of pain:	1	2	3	4	5	6	7	8	9	10
On a scale of 0 -10 list your **AVERAGE** level of pain:	1	2	3	4	5	6	7	8	9	10
On a scale of 0 -10 list your **WORST** level of pain:	1	2	3	4	5	6	7	8	9	10

PT#________________

Past Medical History

Blood Pressure:	YES	NO	Heart Disease:	YES	NO
Hypertension	☐	☐	Heart Attack	☐	☐
Low Blood Pressure	☐	☐	Atherosclerotic Disease	☐	☐
Normal Blood Pressure	☐	☐	Myocardial Infarction	☐	☐
Lungs:	**YES**	**NO**	Rheumatic Heart Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐
Emphysema	☐	☐	Do you have a pacemaker?	☐	☐
Shortness of Breath	☐	☐			

Other Conditions:	YES	NO		YES	NO
Muscular Dystrophy	☐	☐	Diabetes	☐	☐
Rheumatoid Arthritis	☐	☐	Hearing Loss	☐	☐
Multiple Sclerosis	☐	☐	Poor Eyesight	☐	☐
Epilepsy	☐	☐	Fibromyalgia	☐	☐
Gout	☐	☐	Cancer (presently or history of)	☐	☐

Other:____

List all surgeries in the past two years (including dates):________________________________

____

Are you pregnant? ☐ YES ☐ NO

Have you had any injuries related to work? ☐ YES ☐ NO If yes, list body part and date:____________

____

Have you had any Auto Accidents? ☐ YES ☐ NO If yes, list body part and date:____________

____

________________________________ ________________________

Patient Name Date