

PERFORMANCEWEST PHYSICAL THERAPY PATIENT INFORMATION SHEET

PATIENT INFORMATION

(Please be accurate, complete and detailed. Print legibly)

Patient Name: _____ Age: _____ Date of Birth: ____/____/____

Gender: M F Marital Status: *Single Married Divorced* Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: (if different than above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

SYMPTOMS/ INJURY/ ACCIDENT and/or SURGERY INFORMATION

How did you choose our office?: _____ Referring Physician (if applicable): _____

Date of onset of symptoms or injury: ____/____/____ Did you bring a written physician referral?: *Yes No*

(Circle)Pain at worst - *0 1 2 3 4 5 6 7 8 9 10* Pain currently- *0 1 2 3 4 5 6 7 8 9 10* Pain at best- *0 1 2 3 4 5 6 7 8 9 10*

Does pain affect your sleep?: *Yes No* What is your main concern: _____

Are you taking medication for your symptoms? (If so, please list): _____

Describe symptoms: _____

SURGERY (the post-operative condition we will be treating)

Surgeon: _____ Date of surgery: ____/____/____ Facility where performed: _____

Surgery was performed?: _____

INSURANCE/POLICYHOLDER INFORMATION (Parent/guardian information, if under 18)

Insurance Company: _____ Parent/Guardian:(if < 18) _____ Relation: _____

Insurance Policyholder: _____ Policyholder Date of
Birth: ____ / ____ / ____

Address: (if different than patient) _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone #: _____

PRIMARY INSURANCE INFORMATION (Only needed if insurance card is not copied. Please be detailed)

Insurance Company: _____ Phone#: _____

Insurance Policyholder: _____ Policyholder Date of Birth: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Policy # or ID#: _____ Group#: _____

SECONDARY INSURANCE (if applicable) (Only needed if insurance card is not copied. Please be detailed)

Insurance Company: _____ Phone#: _____

Insurance Policyholder: _____ Policyholder Date of
Birth: ____ / ____ / ____

Address: _____ City: _____ State: _____ Zip: _____

Policy # or ID#: _____ Group#: _____

LEGAL CONSENT AND PERSONAL GUARANTEES (Please ask for clarification, if unclear)

- A) I consent to physical therapy treatment provided and supervised by a licensed physical therapist employed by PerformanceWest Physical Therapy.
- B) I agree that I am responsible for this debt regardless of insurance or other reasons and that I will pay any unpaid balance, in full, within 60 days of the date of service. I agree to pay 18% interest per annum on the unpaid balance compounded monthly.
- C) In the event my account is not paid as agreed, or is delinquent, I agree to pay reasonable and standard collection agency, attorney, arbitration, mediation and court fees incurred for the collection of this debt.
- D) I agree and understand that a **\$20.00 fee** can be assessed if I do not show up for a scheduled appointment. This fee will not be covered by insurance. I also understand that I may be asked to reschedule if I am late for an appointment.
- E) In the event industrial or auto insurance benefits are exhausted or there is a refusal to pay for services, I authorize PerformanceWest Physical Therapy to bill my health insurance, give permission to release information to 3rd party carriers, and assign all insurance benefits for services to be paid directly to the above named provider. I certify that a copy of this assignment is as valid as the original.
- F) **I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices.**

Signature: _____ Date _____ / _____ / _____

(This must be a parent or guardian, if under 18) If so, Relationship to patient: