(Office use:) Clinic: *Bountiful Farmington Clearfield Eden* PT initials:_____

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 conset 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 benefitis 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: