Patient Information

Name:_____Birth Date:____/____/_____

Address: _____City: _____ State:_____Zip:_____

Phone (Home):_____Phone (Cell or Work):_____

Email address:_____

Referring Physician (if applicable):_____

Emergency Contact:_____ Phone:_____

How did you hear about us? _____

Medical History

Have you ever had any of the following? (If yes, please explain.)

- Arthritis_____
- Cancer_____
- Diabetes_____
- Epilepsy_____
- Heart Disease_____
- High Blood Pressure_____
- Lung Disease_____
- Recurring Dizziness/Loss of Consciousness_____
- Osteoporosis_____
- Stroke_____
- Surgery (major)_____
- Other_____

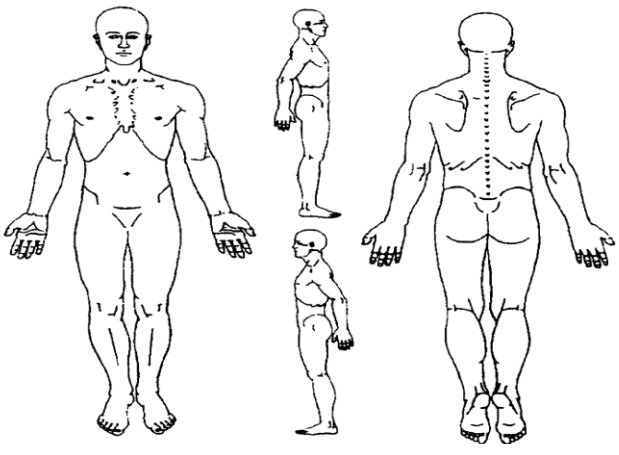
List any other medical problems/conditions/medications that should be mentioned:_____

_____

_____

Pain Diagram

On this drawing, please draw the letter abbreviations on the diagrams that most accurately reflect the type of discomfort that you are experiencing.



Numbness = N Tingling = T
Dull Pain = D Sharp Pain = P
Burning = B Stiffness = S

How would you rate your pain?
(0-10 scale: 0=no pain, 10=maximum pain)

Average:
Worst:
Least:

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ProActive Physical Therapy and Performance Center
Consent, Financial and Privacy Policy

Consent: I consent to and authorize ProActive Physical Therapy and Performance Center to administer all treatments and services that may be considered advisable in the judgment of my therapist and/or physician in accordance with ProActive's policies. I understand that the physical therapist may perform testing during the initial visit which may increase my symptoms, as this is a normal physiological response I understand that certain risks such as possible injury and death may occur when participating in a physical therapy program and I hold harmless and release ProActive of any responsibility for any injury, damages or loss of property that may occur during the use of exercise equipment and/or rehab treatments. I agree that if I am not knowledgeable in the proper use of any equipment that I will obtain instruction as well as not use defective equipment and notify staff of such problems. I will abide to the rules and regulations set forth by ProActive and assume all foregoing risks.

I understand that I am personally being billed for any services or supplies that I may receive at ProActive, and I am agreeing to personally pay out-of-pocket and electing not to have my insurance billed. I agree to be fully responsible for any and all charges accrued related to the delivery of physical therapy treatments. I also understand that I may not go back and choose to have a previous session switched from Self Pay to Insurance billed charges.

Payment: Full payment is due at the time of service of each visit. If you anticipate difficulty in paying, please call our office to discuss a payment plan. Any and all outstanding balances over 60 days with no payment plan set-up will be handed over to a Collection Agency.

Minors: The adult/parent accompanying the patient is responsible for full payment of services as described above. Non-accompanied minors coming in for treatment must have prior approval from their parents in order to be treated. Payment must accompany the patient. *Minors of divorced parents*: The parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above, regardless of the divorce decree or settlement.

Privacy Policy: ProActive maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our clinic uses patient information to ensure quality care and appropriate billing for services. You may correct, amend, and/or request a copy of our medical record and history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law. If you have grievance or inquiry pertaining to the privacy of medical records please contact our office.

_____
Please Initial

Missed appointments: In order to provide the best possible service to our patients, we require that notification be given at least **24 hours** in advance to cancel any scheduled PT appointment. Because we commonly have a waiting list, please let us know as soon as possible if you need to cancel or reschedule your appointment. You will be charged **$35.00** for missing a PT appointment without proper notice. This fee will increase to **$70/visit** thereafter. This fee will be directly billed to you and payment is expected at the next scheduled visit.

I have read and understand the above policy and I agree to the terms of this policy.

*

_____ _____

Signature of Patient (or Responsible Party) **Date**