ProActive Physical Therapy and Performance Center
Patient Information Sheet

Please provide the following: physician referral, ALL applicable insurance cards, and driver's license.

Name:_____ Birth date:_____/_____/_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone (Home):_____ Phone (Cell or work):_____

Social Security Number:_____ Email address:_____

Emergency Contact: Name:_____ Phone:_____

How did you hear about us?_____

Referring Physician:_____ Referral Date:_____

Primary Insurance Company:_____ ID#_____ Group#_____

Secondary Insurance Company:_____ ID#_____ Group#_____

(If Applicable) Workman's Compensation/Personal Injury Insurance

Company:_____ Date of injury:_____

Name of Insured:_____ Claim #_____

Adjustor's Name:_____ Phone #_____

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 physician and/or therapist 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 authorize ProActive Physical Therapy and Performance Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to ProActive Physical Therapy and Performance Center. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance.

Signature of Patient:_____ Date:_____

Office Use Only: Auth: Y N Deductible:_____/remain:_____ OOP:_____/remain:_____

Co-pay:_____ Co-insurance:_____ Allowed Visits:_____ Cap used:_____

Medical History

Name:_____

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:_____

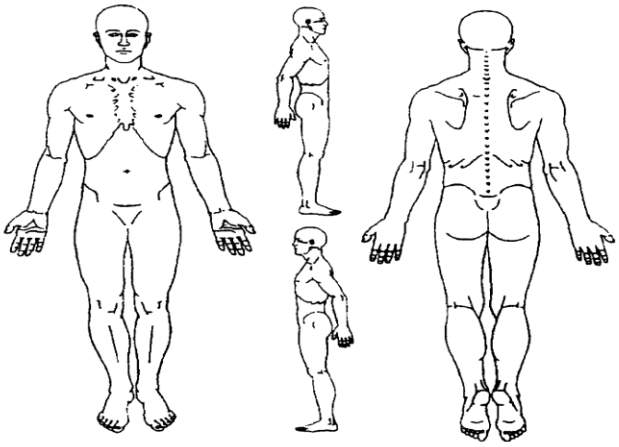
_____

_____

_____

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?
(Rated out of 10: 0 = no pain, 10 = maximum pain)

Worst: /10

Least: /10

Average: /10

ProActive Physical Therapy and Performance Center
Financial and Privacy Policy

Thank you for choosing ProActive Physical Therapy & Performance Center for your physical therapy needs. Your understanding of our financial and privacy policy is an essential part of your treatment here at ProActive PT Center. You are responsible for notifying us of ANY and ALL changes to your insurance coverage, address, phone numbers, and employment status, if applicable. *Please be aware, that verification of PT benefits is NOT a guarantee of payment. You are responsible for full payment of physical therapy services rendered by ProActive Physical Therapy and Performance Center.*

I. **Insured patients:** We will file claims with those insurance plans with which we are contracted. You are responsible for knowing the terms and conditions of your insurance policy including those regarding financial obligations, referrals and prior authorizations. By law, you are responsible for: co-pays (paid at each visit), deductibles, co-insurance expenses, and supplies (not covered by insurance). If your health plan determines a service is not covered, or applies the service to your deductible or co-insurance, full payment of these services is due to ProActive Physical Therapy and Performance Center. Once insurance has made payment for services, we will bill you for the remaining amount. The billing process and prices are set by the Health Care Financing Administration (HCFA) and we follow the Colorado standard for pricing and billing. ProActive will accept reimbursements that your personal insurance policy allows. We will bill you accordingly. If services are considered out-of-network or denied by your insurance, you will not be "full-balance" billed.

II. **Non-insured patients:** ProActive offers a cash rate to those who do not have insurance coverage. Full payment is due at the time of service of each visit.

III. **Payment**: All amounts related to co-pays, deductibles, co-insurances and supplies will be your responsibility. Payment plans are available on an individual basis. Delinquent balances over 60 days with no payment plan set up will be subject to late finance charges of up to 5% per month ($5.oo minimum charge). Outstanding balances over 90 days with no payment plan or patient correspondence may be subject to a collection agency.

IV. **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 for insured or non-insured patients, regardless of the divorce decree or settlement. It is the requesting parent's responsibility to know the terms and limits of the insurance.

V. **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 initially charged **$35.00** for missing a PT appointment without proper notice. This fee will increase to **$70.00/visit** thereafter. This fee is not covered by insurance and will be directly billed to you. Payment is expected at the next scheduled visit.

If you have questions regarding our financial policy or your financial responsibilities, please ask us.

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

*

_____ _____

Signature of the Responsible Party **Date**

_____

Patient name (please print)