



**PLEASE PRINT CLEARLY**

Mr. Mrs. Ms. Miss. Dr. NAME: (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SEX ASSIGNED AT BIRTH:  FEMALE  MALE

GENDER IDENTITY: \_\_\_\_\_ PREFERRED PRONOUNS (Ex: her, him, them): \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

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INSURED'S NAME: (First) \_\_\_\_\_ (Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

INSURED'S ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

INSURED'S HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ INSURED'S DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

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NAME OF EMERGENCY CONTACT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE (\_\_\_\_\_) \_\_\_\_\_ RELATION TO THE PATIENT: \_\_\_\_\_

I hereby authorize Performance Physical Therapy through its appropriate therapy personnel, to perform an evaluation and treatment procedures deemed necessary by the therapist, on me or the above named patient, if different than myself.

PATIENT SIGNATURE: (Parent if minor) \_\_\_\_\_ DATE: \_\_\_\_\_



## **PATIENT RESPONSIBILITY**

**\*\*\*\*\*IMPORTANT\*\*\*\*\***

**Performance Physical Therapy CANNOT guarantee that the insurance benefit information we obtain from your insurance carrier is correct. For this reason, we require you to contact your insurance carrier to confirm your specific benefits.** We make every attempt to accurately confirm your financial responsibility for your rehabilitation and provide this information to you in the form of a copy of the Benefits Confirmation sheet. Please refer to this sheet if you have a question regarding the information given to us by your insurance provider, such as the amount of your deductible, if that is a feature of your coverage. Since your provider applies claims against your deductible from various sources, we can not track this amount for you. It is your responsibility to be aware of your deductible amount, as well as any/all financial responsibilities you may incur.

Co-pay and coinsurance charges are based on the information your insurance company provides when we call for your benefits, however, the amounts are estimates. The final amounts due are determined by your insurance company at the time the claims are received and processed, and sometimes this amount differs from what we collect at the time of service.

It is understood that the FINAL DETERMINATION OF CO-PAY/COINSURANCE RESPONSIBILITY is taken from the Explanation of Benefits received from the patient's insurance company. The patient is aware that he/she may owe more as a result of the above procedure.

I hereby authorize Performance Therapy to release to the appropriate agencies, any information acquired in the course of my evaluation and treatment, necessary to process claims and pay Performance Physical Therapy directly for the professional services rendered.

**The patient further fully understands that he/she will be billed and financially responsible for any and all charges not paid by their insurance company. If your balance accrues to over \$300.00 during your physical therapy treatment your treatment may be put on hold until a payment is received.**

## **ATTENDANCE POLICY**

It is important that you keep your scheduled appointments. You are more likely to see steady progress and maximize your insurance coverage by attending consistently. Your regular attendance also allows us to meet the needs of all of our patients effectively.

**In the event that you are late for your appointment, your therapist reserves the right to reschedule.**

If you have a scheduled appointment that must be cancelled, please provide at least 24 hours advance notice to avoid a **\$50.00 cancellation fee**. Failure to provide a 24-hour notice will result in the cancellation fee being added to your account.

**Children under 18: Guardians must sign in the front desk for the minor as well as accompany them out of each Physical Therapy session due to safety reasons.**

**I hereby authorize Performance Physical Therapy through it's appropriate therapy personnel, to perform an evaluation and treatment procedures deemed necessary by the therapist, on me or the above named patient, if different than myself.**

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Signature (parent or guardian if under 18): \_\_\_\_\_

Date: \_\_\_\_\_





## Medication List

Date: \_\_\_\_\_

Print First Name: \_\_\_\_\_

Print Last Name: \_\_\_\_\_

<u>Medication</u> (Print Clearly)	<u>Dose</u> <u>Given</u>	<u>Frequency</u> (ex: 1x daily)	<u>Time</u>	<u>AM/PM</u>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Patient Health Questionnaire (PHQ-2)**

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

2. Feeling down, depressed, or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

