Performance Physical Therapy
And Rehabilitation, PC
A member of PT-MDkinect

Patient Information

Full Name:		DOB:___/___/_____	SSN:
Address:		City/State:	Zip:
Phone: (home)	(cell)	(work)	
Email Address:			Sex: M/F
Referred By:		Referring Physician Phone:	
Address:		City/State:	Zip:
Primary Care Doctor:		Office Phone:	
Address:		City/State:	Zip:
Have you had Therapy in the last year? Y/N Type: PT OT Speech		Emergency Contact Relationship:	Phone#:
If yes then where was your therapy?		If yes how many therapy visits?	

Condition Information

Is your condition due to an accident? Y/N		Date of Accident:
Type of Accident: Auto/Work/Home		If other, please qualify:
Did you file a claim? Y/N	Adjuster's Name: Claim #:	Adjuster's Contact Number:
Do you have an attorney? Y/N	Attorney's Name:	Attorney's Contact Number:
Please provide any additional information:		

Insurance Information

Primary Insurance

Primary Insurance Plan:			
Policy Holder Name:			
Relationship to Policy Holder:			
Employer of Policy Holder:			
ID Number:		In Network? Y/N	
Group Number:		Phone:	
Address:			
City/State:		Zip:	
Medicare Replacement Plan? Y/N		Deductible in OOP? Y/N	
Pre-existing Clause in Effect? Y/N		COBRA Plan? Y/N	
Benefits Confirmed by:			Date:
Reference Number:			

Secondary Insurance

Secondary Insurance Plan:			
Policy Holder Name:			
Relationship to Policy Holder:			
ID Number:	Group Number:		Phone:
Address:			
City/State:		Zip:	

It is a requirement of your insurance company to complete this section in order to provide up to date information.

Patient Name:	Date of Birth:

Acknowledgement of receipt of notice of Privacy Practices

By signing below, I acknowledge that I have been offered or provided a copy of *Performance Physical Therapy's* Notice of Privacy Practices.

Consent to Treat

I authorize Performance Physical Therapy to render services as deemed necessary for the care of the above named Patient.

HIPAA Medical Information Release

Release of Information:

[ ] I authorize the release of information from Performance Physical Therapy, a member of Pt-MDkinect LLC, including the diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number ____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] do not leave a message
[ ] (other)_____

The best time to reach me is (*day*)_____ between (*time*)_____

Your signature below indicates:

1. You read and understand the Acknowledgement of receipt of Notice of Privacy Practices
2. You understand and agree to the Consent to Treat
3. You read and understand the Medical Information Release.

Patient Signature:	Date:
Witness:	Date:

Patient Name:	Date of Birth:

Assignment of Medical Insurance Benefits

Thank you for choosing Performance Physical Therapy, a member of Pt-MDkinect LLC. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.
Payment is expected at the time of service unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

I acknowledge that it is my responsibility to:

1. Provide complete up-to-date information on medical insurance coverage for the patient.
2. Present a valid insurance card when requested.
3. Pay applicable copayment at the time of service.
4. Present a valid referral or authorization number for all services (if required by my insurance company).
5. Inform the office if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
6. Make payment within 30 days any balance on my account for any amount due such as deductibles, coinsurance, co-payments, or non-covered services.

Payment Policy

I am ultimately responsible to pay the medical bill if my insurance company does not honor the assignment of benefits in whole or in part. Payments may be arranged. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include any attorney fees.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Performance Physical Therapy, a member of Pt-MDkinect LLC .
5. You have read and understand the Payment Policy.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	