ProFormance Rehab, Inc.

PATIENT REGISTRATION

Name: _____Today's Date: _____
Address: _____ DOB: _____ Age: _____
City: _____State: _____ Zip Code: _____
Home #: _____Work #: _____ Cell #: _____
Email: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Phone #: _____

Reason for today's visit:
_____
Referring Dr: _____ Phone #: _____
Primary Care Dr: _____ Phone #: _____

INSURANCE INFORMATION:
Private Insurance: _____
Billing Address: _____
Phone #: _____ Subscriber: _____DOB: _____
ID #: _____ Group #: _____

CAR ACCIDENT: Date of Accident: _____
PIP Insurance Co: _____ Claim #: _____
Billing Address: _____City: _____ State: _____
Adjuster: _____ Phone #: _____

WORK RELATED INJURY: □ Department of L&I or □ Worker's Comp/Self Insured
Date of Injury: _____Claim #: _____ Employer: _____
Adjuster: _____ Phone#: _____
If self insured, please provide billing address:

Have you had Physical Therapy in the past related to this claim: YES or NO
_____

************WE BILL PRIMARY INSURANCE ONLY************

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance and hereby authorize you to evaluate & treat me (or my dependent) & I assign directly to ProFormance Rehab, Inc. all medical benefits, if any, for services rendered. I authorize the release of all information necessary to secure payment of benefits. I authorize the release of medical and billing information to my referring physician or insurance company if requested.

_____
SIGNATURE OF INSURED/GUARDIAN DATE

ProFormance Rehab, Inc.

BILLING POLICY

IF WE ARE BILLING YOUR INSURANCE COMPANY PLEASE CONTACT YOUR INSURANCE FOR THE FOLLOWING INFORMATION BEFORE YOUR APPOINTMENT WITH US.

QUESTIONS THAT NEED TO BE ANSWERED SO THAT YOU KNOW YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS ARE:

Our provider tax id # is, 91-2112632

- Outpatient physical therapy benefit %: _____
- Do have a dollar/visit max per year? Yes/No Amount? _____
- Are custom orthotics covered on your plan? _____
- Do you have a deductible or co-pay? _____
- Is Proformance Rehab a provider with your insurance? _____
- Do you need a Prescription or Referral for PT? _____

(MOST INSURANCE COMPANIES REQUIRE A WRITTEN AUTHORIZATION FROM YOUR DOCTOR. PLEASE BE SURE YOU HAVE THIS WITH YOU OR ON FILE HERE.)

► PLEASE SIGN BELOW ◄

We are providers for many insurance companies for example, Regence Blue Shield, Blue Cross/Blue Shield, Premera Blue Cross, First Choice, Aetna, Uniform Medical, L&I, and all Workers Comp. carriers. If your visit with us is Motor Vehicle Related we will only bill PIP coverage, we do not accept 3rd party claims. For privately insured patient's we will bill your primary insurance only. We expect payment within 60 days of the date of service by you or your insurance. **We are not MEDICARE providers** and cannot bill Medicare or supplemental coverage.

Payment for any co-pay's or supplies should be paid at the time of your visit. This includes patients who get orthotics. **We accept CASH, CHECK, VISA AND MASTERCARD.**
ProFormance Rehab will charge a $25.00 NSF check fee if necessary.

CANCEL/NO SHOW POLICY:
We ask that you call 24 hours in advance, Monday-Friday, if you need to cancel or reschedule your appointment. Failure to do so will result in a $75.00 charge which is not payable by insurance.

This is a verification of your benefits as described by your insurance company. This is not a guarantee of payment. All payments are subject to the member's eligibility at the time the claim is processed. I understand that ProFormance Rehab, Inc. will bill my insurance company directly, but that I am personally responsible for any copays, deductibles, or balances incurred. If my insurance company denies claims or my claims go to medical review I understand I am financially responsible for all services.

_____

SIGN DATE

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Proformance Rehab for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Proformance Rehab.

I understand that diagnosis or treatment of me by **Proformance Rehab** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Proformance Rehab is not required to agree to the restrictions that I may request. However, if **Proformance Rehab** agrees to a restriction that I request, the restriction is binding on Proformance Rehab.

I have the right to revoke this consent, in writing, at any time, except to the extent that Proformance Rehab has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Proformance Rehab's Notice of Privacy Practices prior to signing this document.

The Proformance Rehab's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Proformance Rehab.**

This Notice of Privacy Practices also describes my rights and the duties of **Proformance Rehab** with respect to my protected health information.

Proformance Rehab reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Proformance Rehab's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative’s Authority

ProFormance Rehabilitation
2815 Eastlake Ave E, Suite 170, Seattle, WA 98102
p. (206)322-2842 f. (206)322-6232

Medical History Questionnaire

Name: _____
Referring Provider: _____
Diagnosis: _____
Birthdate: _____Age:_____

What problem or complaint can we help you with today? _____
_____

Is this related to an injury or accident? Yes □ No □ Date of accident: _____
If yes, check which applies: Work □ Motor Vehicle □ Other (specify) □ _____
Are you currently off work because of this problem? Yes □ No □ Light Duty □
If yes, last day worked: _____ Occupation: _____
How and when did your symptoms start? _____Date:_____
Have you had this problem before? _____
What tests or treatment have you had for this problem? _____
Have you had any diagnostics? Xrays □ MRI □ Bone Scan □ CAT scan □ Nerve tests □ Blood tests □
Other□ Results: _____
Have you had surgery relating to this condition? Yes □ No □ Explain:_____Date:_____
List all medications you are currently taking for this or other problems: _____
_____

Currently, would you say your health is: Excellent □ Good □ Fair □ Poor □

Have you had any of the following:

Weakness □	Numbness or tingling □	Dizziness or nausea □
Headaches □	Change in bowel/bladder □	Pain with cough/sneeze □
Blurred vision □	Balance problems or Falls □	Dropping things □
Night pain □	Unexplained weight loss □	Fainting/drop attacks □

What is your pain intensity? (please circle below)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

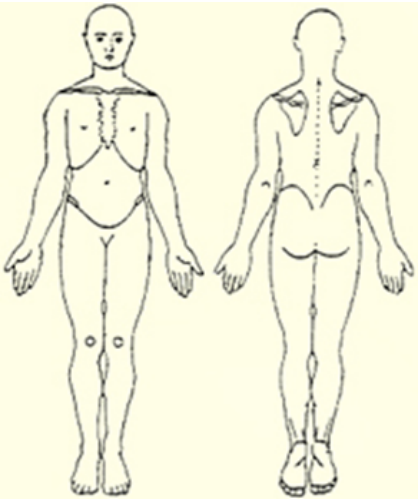
Which of these words describe your pain?

Sharp □	Dull □	Aching □	Burning □	Radiating □	Numb/tingling□
Radiating □	Constant □	Intermittent □	Buckling □	Locking □	Giving way □

Other □ _____

Do you have days or periods of time when you are completely pain free? Yes □ No □

Please indicate your painful areas:



How is your current condition progressing overall?

Improving □ Staying the same □ Getting worse □

What makes your problem (s) better? Heat □ Ice □ Rest □ Medication □ Change in position □

Exercise □ Other □ _____

What makes your problem(s) worse? Sitting □ Standing □ Walking□ Twisting □ Bending □ Squatting □

Stairs □ Rising from chair □ Pushing/pulling □ Kneeling □ Reaching □ Lifting □ Reclining □

Other □ _____

Are you able to continue your usual recreational activities? Yes □ No □ Limited □ (explain) _____

_____

Please list your usual exercise habits/sports/recreational activities: _____

_____

How many days per week do you exercise? _____ Average # minutes per day? _____

Have you had any falls in the past year? Yes □ No □

Are you currently pregnant? Yes □ No □ Not Applicable □

Have you had any of the following at any time in your life? Please circle.

Asthma	Allergies	Lung problem	Heart disorder	High Blood Pressure
Lupus	Stroke	Fibromyalgia	Diabetes	Bleeding disorder
Polio	Tuberculosis	Osteoporosis	Blood Clots/DVT	Concussion
Cancer	Arthritis	Seizures	Broken bone	Major Accident/Trauma
Whiplash	Sprain/Strain	Nerve disorder	Metal Implant	Headaches
Anxiety	Depression	Connective tissue disorder	Allergy to latex/adhesives	

Orthopedic Surgery: _____ Other Surgery: _____

Please explain any circled items: _____

_____

Any other conditions we should be aware of? _____

What are your goals that you are hoping to achieve with physical therapy? _____

_____