

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 3<sup>rd</sup> 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 \$40.00 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

# MEDICAL HISTORY FORM

## 1. Name

Last	First	MI
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## 2. Current

**Complaints/Injury:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. **Are you:**  Right-handed  Left-handed

## 4. Employment

- Work outside of home       Student  
 Homemaker                       Retired  
 Unemployed

Occupation: \_\_\_\_\_

How many hours do you spend in computer/desk work per day? \_\_\_\_\_

How much and how often do you lift objects heavier than 10 pounds?

# of times/day: \_\_\_\_\_

Average weight of objects lifted: \_\_\_\_\_

## 5. Do you use:

- Cane    Walker    Other \_\_\_\_\_

## 6. Medications

Do you currently take any prescription medications?

- Yes    No   If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you currently take any nonprescription medications?

- Antacids                       Ibuprofen/  
 Antihistamines              Naproxen  
 Aspirin                          Laxatives  
 Decongestants                 Tylenol  
 Herbal supplement          Vitamins

Other \_\_\_\_\_

## 7. Health Habits

Please rate your health:

- Excellent    Good  
 Fair          Poor

Do you exercise beyond your daily activities, or participate in any hobbies or sports?

- Yes    No

Please describe the exercise, sport or hobby: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How many days per week do you exercise or do physical activity? \_\_\_\_\_

For how many minutes, on an average day? \_\_\_\_\_

\_\_\_\_\_

Do you currently use or have you previously used tobacco?

- Yes Cigarettes, # of packs/day \_\_\_\_\_  
Cigars, # per day \_\_\_\_\_  
Chewing tobacco \_\_\_\_\_  
Year quit: \_\_\_\_\_

No

Do you have a history of chemical dependency?

- Yes                       No

## 11. Within the past year, have you had any of the following medical tests?

- |  |   |
|--|---|
| <input type="checkbox"/> Angiogram               | <input type="checkbox"/> MRI                                      |
| <input type="checkbox"/> Arthroscopy             | <input type="checkbox"/> Myelogram                                |
| <input type="checkbox"/> Biopsy                  | <input type="checkbox"/> NCV (nerve conduction velocity)          |
| <input type="checkbox"/> Bone scan               | <input type="checkbox"/> Pulmonary function test                  |
| <input type="checkbox"/> CT scan                 | <input type="checkbox"/> Stress test (such as treadmill, bicycle) |
| <input type="checkbox"/> Doppler ultrasound      | <input type="checkbox"/> X-rays                                   |
| <input type="checkbox"/> Echocardiogram          |   |
| <input type="checkbox"/> EKG (electrocardiogram) |   |
| <input type="checkbox"/> EMG (electromyogram)    |   |

Results of medical tests \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## 12. How did you hear about ProFormance Rehab?

Doctor/referring provider? \_\_\_\_\_

Friend/colleague? Their name: \_\_\_\_\_

\_\_\_\_\_

Other? \_\_\_\_\_

