

# PERFORMANCE PHYSICAL THERAPY

OF NAPLES, INC.

Complete Orthopedic, Sports, and Spine Rehabilitation

## PATIENT REGISTRATION

PLEASE PRINT FULL NAME \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SEX: M \_\_\_\_\_ F \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPARATED \_\_\_\_\_

LOCAL ADDRESS: \_\_\_\_\_  
P.O. BOX OR STREET ADDRESS CITY STATE ZIP

NORTH ADDRESS: \_\_\_\_\_  
P.O. BOX OR STREET ADDRESS CITY STATE ZIP

PRIMARY NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SECONDARY NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Home Other: \_\_\_\_\_ Cell Home Other: \_\_\_\_\_

EMAIL: \_\_\_\_\_ EMERGENCY CONTACT: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

ARE YOU THE PRIMARY POLICY HOLDER? YES - NO

If you are not the primary policy holder, please complete the fields below:

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER SS#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY/SUPPLEMENT INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER SS#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

### IF THIS WAS AN ACCIDENT COMPLETE THE FOLLOWING INFORMATION:

INSURANCE COMPANY: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

CASE ADJUSTER: \_\_\_\_\_ PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ (CIRCLE ONE): AUTO - FALL - WORK ACCIDENT - OTHER

*I understand that if I do not cancel an appointment 24 hours in advance I will be charged a \$50.00 cancellation fee.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## Consent for Treatment

### New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my health care, Performance Physical Therapy of Naples, Inc. originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations

I understand that Performance Physical Therapy of Naples, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Performance Physical Therapy of Naples Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Performance Physical Therapy of Naples, Inc. change their notice, they will send copy of any revised notice to the address I've provided, (whether U.S mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

*No Restrictions*

*I Have Restrictions Listed Below*

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**P E R F O R M A N C E**  
**P H Y S I C A L T H E R A P Y**  
**O F N A P L E S , I N C .**

Complete Orthopedic, Sports, and Spine Rehabilitation

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**Insurance Assignment/Authorization to Release Confidential  
Information/ Consent for Treatment**

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1. \_\_\_\_\_ (initials) **I understand that should I not provide 24 hours notice to Performance Physical Therapy of Naples, Inc. to cancel my appointment, I will be charged a No Show/Cancellation fee of \$50.00, which cannot be waived.**
2. \_\_\_\_\_ (initials) I give my consent for a physical therapy evaluation and treatment to be administered by Performance Physical Therapy of Naples, Inc.
3. \_\_\_\_\_ (initials) If this is a Workman's Compensation claim or a motor vehicle claim, I authorize the release of information to claim adjusters, case managers and employers.
4. \_\_\_\_\_ (initials) I authorize medical information to be released from my chart to my physician. I also authorize medical information to be released to my insurance carrier as needed for billing purposes.
5. \_\_\_\_\_ (initials) I understand that I am responsible for payment of services rendered. Billing will be done from this office to my insurance carrier and I will be responsible for my deductible. I am aware that I am responsible for co-pay amounts dictated by my insurance carrier. I will be charged "usual and customary amounts" based on the fee schedule for rehabilitation that my insurance carrier has developed or allowed.
6. \_\_\_\_\_(initials) I understand that Performance Physical Therapy of Naples, Inc., will verify my insurance benefits as a courtesy and collect copayments, coinsurance and deductibles based on an estimates only provided by your insurance carrier. Should my insurance carrier deny or make partial payment, I understand that I am responsible for any remaining balances.
7. \_\_\_\_\_ (initials) I authorize my insurance carrier to directly pay Performance Physical Therapy of Naples, Inc. for service appropriately rendered and billed for.
8. \_\_\_\_\_ (initials) I recognize that it is my responsibility to remit checks issued directly to me from my insurance carrier to Performance Physical Therapy of Naples, Inc. if my insurance carrier issues payment to me for services rendered and I have a remaining balance with Performance Physical Therapy of Naples, Inc.

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

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## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Treatment related to condition

Have you seen any other healthcare professional in regards to your current ailment?  Yes  No

If yes, please list them below and when you last saw them.

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

### Surgical History (Check Box)

	<u>Date of Surgery</u>	<u>Date of Surgery</u>
<input type="checkbox"/> Knee Arthroscopy	<input type="checkbox"/> L <input type="checkbox"/> R _____	<input type="checkbox"/> Neck Surgery _____
<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> L <input type="checkbox"/> R _____	<input type="checkbox"/> Back Surgery _____
<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> L <input type="checkbox"/> R _____	<input type="checkbox"/> Cancer Removal _____
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Heart Procedure (Bypass or Stent)	_____	_____

### Medical Condition (Check Box)

<u>Medical Condition (Check Box)</u>	<u>Date Began</u>	<u>Date Began</u>
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Cancer (Type) _____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> Pacemaker _____
<input type="checkbox"/> Cardiac Arrhythmia	_____	<input type="checkbox"/> Other _____

### Medications

*\*\*\*If you have a medication list, please allow us to copy it at the front desk\*\*\**

#### Current Medications

#### Dosage

#### Frequency

#### Reason

_____	_____	1 2 3 /Day, or As Needed	_____
_____	_____	1 2 3 /Day, or As Needed	_____
_____	_____	1 2 3 /Day, or As Needed	_____
_____	_____	1 2 3 /Day, or As Needed	_____
_____	_____	1 2 3 /Day, or As Needed	_____

### Fall History (Check Box)

Have you had any falls within the last 12 months?

Yes  No

If yes, how many? \_\_\_\_\_

Have any resulted in injury?

Yes  No

### Pain Scale (Please Circle Worst Pain Level within Last Few Days)



Performance Physical Therapy of Naples, Inc.

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