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

CELL PHONE NUMBER: (_____) _______- ___________ HOME PHONE NUMBER: (_____) _______- __________

WORK NUMBER: (_____) _______- ___________ OUT OF STATE NUMBER: (_____) _______- ___________

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

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

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 INFORMATION - Commercial

Patient Name: ______________________ Date: ______________

Height: ____________ Weight: ____________ Age: ____________

Surgical History (Check Box)

			Date of Surgery		Date of Surgery
☐Knee Arthroscopy	☐ L	☐ R	____________	☐Neck Surgery	____________
☐Knee Replacement	☐ L	☐ R	____________	☐Back Surgery	____________
☐Hip Replacement	☐ L	☐ R	____________	☐Cancer Removal	____________
☐Shoulder	☐ L	☐ R	____________	☐Other	____________
☐Heart Procedure (Bypass or Stent)			____________	____________________	

Pain Scale (Please Circle Worst Pain Level in the Last Few Days)

Treatment related to condition	Start Date	End Date	Improved?
☐Primary Physician	____________	____________	☐ Y ☐ N
☐Orthopedic Surgeon	____________	____________	☐ Y ☐ N
☐Physical Therapy	____________	____________	☐ Y ☐ N
☐Pain Management Clinic	____________	____________	☐ Y ☐ N
☐Neurologist	____________	____________	☐ Y ☐ N

Medical Condition (Check Box)

	Date Began		Date Began
☐High Blood Pressure	____________	☐Cancer (Type)	____________
☐High Cholesterol	____________	☐Osteoporosis	____________
☐Diabetes	____________	☐Stroke	____________
☐Osteoarthritis	____________	☐Pacemaker	____________
☐Cardiac Arrhythmia	____________	☐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	____________

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

***Quick*DASH DISABILITY/SYMPTOM SCORE** = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may not be calculated if there is greater than 1 missing item.