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	_____