

DSC Performance Physical Therapy

WELCOME TO OUR OFFICE!

By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

PLEASE COMPLETE EACH SECTION TO THE BEST OF YOUR ABILITY.

CONTACT INFORMATION

Date: _____/_____/_____

Name: (last) _____ (first) _____ (M.I.) _____

Street Address: _____ (apt. #) _____

(city) _____ (zip) _____

Phone: (home) (_____) _____ - _____ (cell) (_____) _____ - _____ Email
address: _____ @ _____ Birth

date: ____/____/____ Age: ____ Sex: _____ Married? Yes No

Right / Left Handed?

Emergency contact: _____ Phone: (_____) _____ - _____

Referred by: _____ Phone: (_____) _____ - _____

EMPLOYMENT INFORMATION / STUDENT INFORMATION

(FOR WORKER'S COMP PLEASE FILL OUT ADDRESS AS WELL)

Employer: _____ Phone: (_____) _____ - _____

Street Address: _____ (apt. #) _____

(city) _____ (zip) _____

If student, school name: _____ Year in school: _____

INSURANCE INFORMATION

Please fill out the following insurance information to the best of your knowledge and provide a copy of your driver's license and insurance card(s) to the office staff.

Name of Primary Medical Insurance: _____ Type: PPO HMO EPO

Name of Insured: _____ Relationship: _____ If

name of insured is not you, please give their name and D.O.B. _____

Policy Number: _____ Group: _____

Name of secondary insurance company (if applicable): _____

Policy Number of Secondary Insurance (if applicable): _____

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MEDICAL HISTORY

Please complete this page to the best of your knowledge. Please include ALL pertinent information regarding the injury you are currently seeking treatment for, as well as any past injuries or surgeries.

Referring Physician: _____ Phone: (_____) _____ - _____

Primary Care Physician: _____ Phone: (_____) _____ - _____

Area(s) to be treated: _____

When did your symptoms begin: _____

Have you had previous treatment for this problem? Yes No

If Yes, where was treatment provided: _____

If Yes, what treatment was provided: _____

Have you had surgery related to this condition? Yes No

If Yes, please list Doctor, date, and type of surgery: _____

Have you had previous physical therapy for this or any other condition? Yes No

If Yes, for what? _____

If Yes, when and where did you receive treatment? _____

If Yes, how many visits did you have? _____

Are you currently taking any medications? Yes No

If Yes, please list ALL medications: _____

ALLERGIES: (Please list all allergies, medical, food, etc.) _____

Do you now have/or have you ever had any of the following conditions (Please circle):

Alcoholism	Yes	No	Gout	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No
Edema (swelling)	Yes	No	Liver Disease	Yes	No
Bleeding Disorder	Yes	No	Mental Illness	Yes	No
Diabetes	Yes	No	Migraine Headaches	Yes	No
Emphysema	Yes	No	Pacemaker	Yes	No
Epilepsy	Yes	No	Stomach Ulcers	Yes	No
Glaucoma	Yes	No	Asthma	Yes	No
Drug Abuse	Yes	No			

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Female Patients

Are you pregnant? Yes No Date of last period: _____/_____/_____

If you answered yes to any of these, did you have to have surgery for the condition(s)? Yes No

If Yes, explain _____

Please provide explanation if you now have or have ever had any of the following conditions:

Cancer Yes No When diagnosed: _____

If Yes, describe _____

Heart Trouble Yes No When diagnosed: _____

If Yes, what kind (explain) _____

Stroke Yes No When diagnosed: _____

If Yes, when _____

Tuberculosis Yes No When diagnosed: _____

If Yes, explain _____

HIV/AIDS Virus Yes No When diagnosed: _____

If Yes, explain _____

Hepatitis A, B, or C Yes No When diagnosed: _____

If Yes, explain _____

Have you ever had any of the following operations (Please circle):

Appendix Yes No If Yes, when _____

Gallbladder Yes No If Yes, when _____

Hernia Yes No If Yes, when _____

Hysterectomy Yes No If Yes, when _____

Stomach Yes No If Yes, when _____

Tonsils Yes No If Yes, when _____

Any other surgeries you may have had but are not listed here:

Welcome to DSC Performance Physical Therapy! We are committed to serving your health care needs with dedication, professionalism, and compassion. Your understanding of our financial policy is important to our professional relationship. Please be advised of the following:

Disclosure Statement and Consent for Medical Treatment

This information is true and correct to the best of my knowledge. I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of the physician/therapist and I authorize this medical clinic and the physician/therapist to furnish information to the insurance carriers of this treatment. I also agree to any and all medical examinations, diagnostic and therapeutic recommendations as ordered or viewed as medically necessary per the Doctors and Physical Therapists at DSC Performance Physical Therapy.

Patient/Guardian Signature: _____ Date: ____/____/____
Relationship of other responsible party: _____ Date: ____/____/____

General Permission for Release of Medical Records

I _____ am hereby authorizing DSC Performance Physical Therapy direct access to my medical records, history's, laboratory results, etc., if available, per this request. I understand the medical confidentiality still prevails for both parties. I am also authorizing DSC Performance Physical Therapy to provide release of necessary documentation to my insurance carrier in order to secure payment of claims for services rendered. I am also authorizing DSC Performance Physical Therapy to provide release of necessary documentation to my insurance adjustor, and/or attorney if applicable.

Assignment of Insurance Benefits and Private Insurance Waiver

1. I hereby authorize payment directly to DSC Performance Physical Therapy of benefits due me for services rendered. I also hereby authorize DSC Performance Physical Therapy to furnish information to my insurance carrier as necessary to secure payment of benefits, and hereby assign to DSC Performance Physical Therapy any and all payments for services rendered.
2. I further agree that a photocopy of this agreement shall be as valid as the original.
3. I understand in the event any check or credit card payment is not honored by my bank or financial institution that I will be charged a service fee of \$25.00, and I will be responsible to make immediate restitution to my account balance. I understand that subsequent visits may be on a cash basis only.
4. I understand that if my insurance carrier refuses to pay and/or process my claims or denies to authorize medical treatment for services rendered, that I will be financially responsible for the charges incurred at this facility.

Office Policy and Payment Terms

Payment of co-payments, anticipated co-insurance, and deductibles will be collected in full and is due at the time services are rendered. For your convenience, DSC Performance Physical Therapy accepts Visa, MasterCard, American Express, Discover, Cash, and Check. It is the responsibility of the patient/member to verify that our office is affiliated with their insurance carrier or PPO. Also, it is the responsibility of the patient/member to understand their benefits and any plan restrictions or plan

limitations. Please contact your insurance carrier directly for questions regarding your benefit limitations.

We will provide you with an itemized statement of services or insurance claim form upon request. As a courtesy, DSC Performance Physical Therapy does provide insurance billing services. However, accounts not resolved within ninety (90) days from the date services were rendered, may be referred to any outside collection agency.

Any and all co-payments, deductibles and co-insurance are due and payable at time of services. Professional services are charged to the patient. As a courtesy to you, we will complete necessary forms to help expedite insurance carrier payments, however, the patient is ultimately responsible for all fees, regardless of insurance coverage.

Important DSC Performance Physical Therapy Policies

Late Policy “15-Minutes”

Being late by more than 15 minutes may require your session to be modified or even canceled at the discretion of the staff.

Advance Notice

If you wish to cancel an appointment please call as soon as possible. Advance notice allows us to fill the time slot which was reserved for you. Please be courteous to the staff by allowing the maximum amount of time for your appointment. Thank you.

Cancelation/No-Show Policy

If you fail to show for 3 appointments without notice, all further appointments you have scheduled will be removed. You may contact us and reschedule appointments on a “first come, first serve” basis, but it will not be guaranteed.

Please provide our office with 24 hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or who fail to provide 24 hour notice to change a scheduled appointment will be responsible for a **\$50.00 service fee**. (initial here) _____

Patient Responsibility Payment Extensions are available

All co-payment, co-insurance, or deductible payments must be paid at the time of your treatment. Any other arrangements must be made in person with the clinical director.

I have carefully read and agree to all the above policies. In the event such policies are broken, I agree to the consequences set forth.

Patient Signature: _____ Date: ____/____/____

CREDIT CARD ON FILE POLICY

At DSC Performance Physical Therapy, we require keeping your credit or debit card on file as a convenient method of payment for deductibles, copays, and cancellation fees for which you are liable. Without this authorization, a billing fee of [\$X] will be added to your account for any balances that we must attempt to collect through mailing monthly statement.

Your credit card information is kept confidential and secure and payments to your card are processed only on or after the date of service.

I authorize DSC Performance Physical Therapy to charge the deductibles, copays, and cancellation fees that are my financial responsibility to the following credit or debit card:

- | | | | |
|--------------------------------|---------------------------------|-------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> After ___ Visits |
| <input type="checkbox"/> Amex | <input type="checkbox"/> Visa | <input type="checkbox"/> Mastercard | <input type="checkbox"/> Discover |

Credit Card Number _____

Expiration Date ____/____/____

CCV Number _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, authorize and request DSC Performance Physical Therapy to charge my credit card, indicated above, for balances due for services rendered that are my financial responsibility.

This authorization will remain in effect until I (we) cancel this authorization or I (we) are discharged from DSC Performance Physical Therapy's care. To cancel, I (we) must give a 1 week notification to DSC Performance Physical Therapy and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____/____/____