THERAPIST _____ DATE/TIME _____

PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name_____ Referring Physician _____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell_____ Primary Care Physician_____

Date of Birth_____ SS#_____ Sex_____ Diagnosis_____

Email Address_____ Do you accept text reminders? (Cell#)_____

Emergency Contact_____ Phone_____

Have you had Physical Therapy Before?_____ Where?_____ When?_____ Insurance_____

How did you hear about us? _____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Co. Name_____

ID #_____

Subscriber's Name (If other than patient)_____

Subscriber's Date of Birth_____

Relationship to patient: Spouse Parent Other_____

Copay/Coinsurance_____

SECONDARY

Insurance Co. Name _____

ID # _____

Subscriber's Name (If other than patient) _____

Subscriber's Date of Birth_____

Relationship to patient Spouse Parent Other _____

Benefit _____

WORKMANS COMPENSATION INFORMATION

Insurance Co. Name_____ Claim # _____

Adjustor_____ Phone_____ Ext_____

Employer at the time of Injury _____ Phone_____

Address_____ City_____ State_____ Zip_____

UR Phone_____ UR Fax _____

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name_____ Claim # _____

Adjustor_____ Phone_____ Ext_____

Name of Insured (If other than patient)_____ Relationship_____

PIP Available? _____

Patient Consent Agreement

The following are our office policies. ***Please read carefully*** *before signing, and be sure to ask questions you might have prior to signing this document.*

As a condition of my treatment by Accelerated Performance Rehabilitation I,_____, (Please print name) agree to the following:

1) I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform Accelerated Performance Rehabilitation of any changes to my insurance.
2) I agree to pay any received co-payment at every visit.
3) We request a 24-hour notice in the event of a cancellation. Our intention is to develop a plan of care and schedule to help you get better in a timely fashion. If you are unable to follow your plan of care please have a discussion with your therapist.
4) If my check is returned to Accelerated Performance Rehabilitation for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

7) I authorize Accelerated Performance Rehabilitation to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my condition may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.

Payment Guarantee

8) In consideration of the services rendered and to be rendered by Accelerated Performance Rehabilitation, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

Assignment of Benefits

9) I authorized payment directly to Accelerated Performance Rehabilitation for services rendered.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

ACCELERATED PERFORMANCE REHABILITATION

PAST MEDICAL HISTORY QUESTIONAIRE

Could you be or are you pregnant? YES NO

Do you now or have you ever had any of the following: (Please Check)

	YES	NO		YES	NO		YES	NO
Arthritis			Metal Implants			Osteoporosis		
Cancer/Tumor			High Blood Pressure			Recent Weight Loss/Gain		
Heart Disease			Current Infection (s)			Heart Attack		
Tuberculosis			Pacemaker			Hepatitis		
Vascular Disease			Thyroid Problem			Stroke		
Headaches			Asthma			Head Injury/Concussion		
Shortness of Breath			Hernia			Chronic Cough		
Kidney/Bladder Problems			Fainting Spells			Previous Fractures		
Diabetes			Previous Surgeries			Anemia		
Hearing Loss			Sensitivity to Heat/Cold			Depression		
Anxiety			Swelling in Ankles			Substance Abuse		
Seizures/Epilepsy			Allergies			Deep Vein Thrombosis		

Other, please explain_____

If you answered "YES" to any of the above, please explain and give approximate date (s):

_____

_____

Are you presently taking any medications? If "YES", list all medications:

_____

_____

The information above is correct to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date