



### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone Number: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Patient email address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
 Marital Status: M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ Spouse's Name \_\_\_\_\_  
 Is this injury related to: Work - Yes \_\_\_ No \_\_\_ Auto Accident? - Yes \_\_\_ No \_\_\_  
 Other Yes \_\_\_ Describe \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Is there an attorney involved - Yes \_\_\_ No \_\_\_  
 Family Doctor \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

### PATIENT WORK INFORMATION

Employer's Name: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_ Ext. \_\_\_\_\_

#### Workers Compensation Insurance Information / Auto Injury Insurance – If Applicable

Worker's Comp Carrier: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
 Insurance Adjuster Phone Number: \_\_\_\_\_

#### Primary Insurance

Insured Person Name: \_\_\_\_\_ Is this your coverage? Y \_\_\_ N \_\_\_  
 Insured Date of Birth: \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Contact: \_\_\_\_\_

#### Secondary Insurance

Insured Person Name: \_\_\_\_\_  
 Insured Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
 Policy Name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Contact: \_\_\_\_\_



**Authorization to Release Information and Assignment of Benefits:**

I hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plan to Performance Rehab, Inc. This assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance, and for all services rendered on my behalf or my dependents. I hereby authorize said assignee to release all information necessary to secure the payment. I acknowledge that I have been provided with the Notice of Privacy Practice for Performance Rehab Inc.

**PATIENT /GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Patient Acknowledgement of Receipt of Notice of Privacy Practice**

Performance Rehab Inc will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care options. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. You have the right to review and retain a copy of this notice prior to signing this acknowledgement. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. You may ask us to restrict the use and disclosure of your personal health information. However, we are not required by law to agree to such a request. If we do agree with requested restrictions we are bound by law to follow the agreed upon restrictions.

I acknowledge that I have been provided with the Notice of Privacy Practices for Performance Rehab Inc.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Finance Policy**

All payments (*co-pays or deductible*) are due at the time services are rendered unless arrangements are made prior to treatment. Any balances after payment from all insurances is the Patient's responsibility. If there is no payment from insurance, the full balance will be transferred to the Patient. A fee of \$35.00 will be assessed for all returned checks.

**Attendance Policy**

Patient shall attend all schedule therapy sessions. If Patient is unable to attend, Patient shall contact Performance Rehab at 313-359-9595 and let us know that patient is cancelling an appointment. Consistent attendance will help speed up Patient's recovery. If Patient does not attend and do not call to cancel for three consecutive visits then we will discontinue patient's therapy and notify patient's physician.

**Safety Policy**

1. Please do not touch or use any of Performance Rehab's equipment unless instructed by Patient's therapist.
2. Please do not allow visiting children to touch or use any of Performance Rehab's equipment and children must be supervised closely for their safety.

**No Guarantee**

Patient understands that no guarantee or promises have been made to Patient as to the result of treatment at Performance Rehab. Patient further understands that no representations, warranties, guarantees or promises concerning the results of therapy service is being made or have been made. Patient further understands and agrees that Performance Rehab will not be liable for the loss or damage to any personal property or personal injury. In the event an injury occurs Performance Rehab will take the necessary precautions to prevent further injury.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**Consent to Treatment**

Patient consents to routine physical therapy, occupational therapy, speech therapy and social work services as are deemed necessary by my providers. Patients recognize that while at Performance Rehab facilities, therapy services will be provided by the therapist and/or by support staff under the supervision of the therapists. Patient shall inform the therapist and/or support staff about any health problems, allergies, drug or medications patient is taking. Patient understands that Performance Rehab Physical Therapy is an institution dedicated to learning and providing clinical experience to therapy students. Patient authorizes therapy students affiliated with Performance Rehab to observe and provide therapy services under close supervision of licensed therapist.

**Personal Property:**

I understand and agree that Performance Rehab Physical Therapy shall not be liable for the loss or damage of any personal property which may or may not be given to Performance Rehab staff during my time at one of their institutions.

**Notice of Evaluation and Treatment Techniques**

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, and intervention by use of rehabilitation procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. Performance Rehab strives on making sure that through its therapeutic techniques, the patient and their body mechanics work together in harmony. Performance Rehab treats a variety of medical problems and mal-alignments, including SI Joint problems, Neck and Back problems, Hip & Pelvic problems and other parts of the body. Performance Rehab performs routine evaluations in order to determine the nature and extent of the dysfunction, so that appropriate therapeutic measures can be initiated. Palpation and manual-hands on therapy are necessary parts of Performance Rehab's therapeutic processes, in order to identify the affected area and initiate treatment. Performance Rehab strives to alleviate the pain and discomfort which our patient's experience in the neck, back, shoulders, hip, pelvis, lower extremity and other affected portions of the body through palpation and hands on therapeutic measures.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



## Patient Medical History

**Occupation** \_\_\_\_\_ **Date** \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_ (Date) Accident / Injury \_\_\_\_\_ (date)

What caused your current problem? \_\_\_\_\_

Have you had this problem before? \_\_\_No\_\_\_ Yes – When? \_\_\_\_\_

What has changed in the last 90 days that has made you come to therapy? \_\_\_\_\_

Are your symptoms getting: \_\_\_Better\_\_\_ \_\_\_Worse\_\_\_ \_\_\_No Change\_\_\_

What makes your symptoms better? (i.e. specific med, position, etc.) \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

Describe your PAIN: \_\_\_Intermittent\_\_\_ \_\_\_Constant\_\_\_ \_\_\_Sharp\_\_\_ \_\_\_Dull\_\_\_ \_\_\_Achy\_\_\_ \_\_\_Shooting\_\_\_

**Tests performed & dates:** X-rays \_\_\_\_\_ CT Scan \_\_\_\_\_ MRI \_\_\_\_\_ EMG \_\_\_\_\_

Injections / Nerve Blocks \_\_\_\_\_ OTHER \_\_\_\_\_

Surgery Dates:	Describe	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Dates of treatment for this problem:** Physical Therapy \_\_\_\_\_ MD / DO \_\_\_\_\_  
 Chiropractor \_\_\_\_\_ OTHER \_\_\_\_\_

**How are you treating your problem at home? (i.e. heating pad, hot showers, ice) Does it help?**  
 \_\_\_\_\_

Current Medications:	Drug Name	Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any chance you may be pregnant \_\_\_Yes\_\_\_ or \_\_\_No\_\_\_

Do you have any metal implants in body \_\_\_Yes\_\_\_ or \_\_\_No\_\_\_

Do you have a cardiac pacemaker \_\_\_Yes\_\_\_ or \_\_\_No\_\_\_

**What are YOUR goals to achieve in Physical Therapy?**

\_\_\_Decrease Pain\_\_\_ \_\_\_Increase Joint Motion\_\_\_ \_\_\_Increase Endurance\_\_\_ \_\_\_Increase Strength\_\_\_  
 \_\_\_Increase walking distance\_\_\_ \_\_\_Improve Ability to do Daily Activities\_\_\_ \_\_\_Increase walking distance\_\_\_  
 \_\_\_Return to sports activities\_\_\_ \_\_\_Return to work\_\_\_ \_\_\_Other\_\_\_ \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_