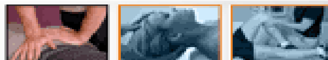

PATIENT INFORMATION

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 __________________________

Performance Rehab

Raising Standard For Physical Therapy

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 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 _______________________________