PERFORMANCE
PHYSICAL THERAPY OF IDAHO

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for circumstances, the discounting or waiving of a patent's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefits plans offered by other third party payers.

Patient Balances and Returned Check Fee
Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance. Our returned check policy requires a $25.00 additional fee for each check returned.

Cases Involving an Attorney Initials _____
If you are receiving services for an auto accident, worker's compensations case or personal injury and you are working with an attorney, we expect a minimum monthly payment of $25.00 in order to continue treatment. We also require information relating to your group health coverage. Your group health and the appropriate auto/ worker's compensation carrier will be billed at the same time unless instructed otherwise. This procedure is necessary in order to have a claim on file with the group health in case the auto/ worker's compensation carrier does not pay or is exhausted at some point during your treatment. The procedure not only protects the clinic of Performance Physical Therapy of Idaho, but you as the patient as well.

Missed Appointments Initials _____
Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you miss a scheduled appointment our policy is to charge a **$25.00 fee** for missed appointments and you will be held responsible for payment.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

By my signature**, I consent to receive Physical Therapy treatment** as prescribed by my physician and given by a qualified licensed Physical Therapist. I have read and understand the above statements in the Release of Information/ Financial Policy concerning my payment responsibility.

_____ _____ _____
Signature of Patient or Responsible Party Print Name Date

Performance Physical Therapy of Idaho
450 W. State Street Suite. 270, Eagle, Idaho 83616
208.462.0808 (t) 208.516.4488 (f)

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General Health Questionnaire

Have you recently noticed any of the following symptoms? Indicate Yes or No:

Yes____No____Fever/Chills/Sweats
Yes____No____Weight Gain/ Loss
Yes____No____Malaise (feeling unwell)
Yes____No____Unusual Fatigue
Yes____No____Nausea/Vomiting
Yes____No____Numbness/Tingling
Yes____No____Weakness
Yes____No____Dizzy/ Loss of Consciousness
Yes____No____Chest Pain/Palpitations

Yes____No____Swelling in Feet or Hands
Yes____No____Difficulty Breathing
Yes____No____Cough/Blood in phlegm
Yes____No____Wheezing
Yes____No____Difficulty Swallowing
Yes____No____Heartburn/Indigestion
Yes____No____Bowel/Bladder changes
Yes____No____Difficulty Urinating (start/stop)
Yes____No____Urine frequency Changes

Have you ever been diagnosed as having any of the following conditions?

Yes____No____Heart Problems
Yes____No____ High Blood Pressure
Yes____No____ Circulation Problems
Yes____No____Rheumatoid Arthritis
Yes____No____Other Arthritic Conditions
Yes____No____Stroke
Yes____No____Lung Disease
Yes____No____Asthma
Yes____No____Pacemaker
Yes____No____Diabetes

Yes____No____Tuberculosis
Yes____No____Cancer
Yes____No____Osteoporosis
Yes____No____Depression
Yes____No____Epilepsy/Seizures
Yes____No____Muscular Disease/Disorder
Yes____No____Hepatitis
Yes____No____Thyroid Problems
Yes____No____Current pregnancy
Yes____No____Other_____

List ALL Surgeries, Medical Conditions or Injuries for which you have been treated:

_____**Date**_____
_____**Date**_____
_____**Date**_____

List ALL Medications you are currently taking (pills, injections, inhalers, vitamins, etc):

_____
_____
_____

The above information is true and complete to the best of my knowledge. I hereby authorize Performance Physical Therapy of Idaho to release any and all information concerning my care to my insurance carrier. I further authorize direct payment to Performance Physical Therapy of Idaho and I understand that I am financially responsible for all charges not covered by my insurance carrier.

Name (please print): _____**Signature**_____
(Patient or Guardian) **(Patient or Guardian)**

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