PERFORMANCE
PHYSICAL THERAPY OF IDAHO

Patient Registration

Thank you for choosing Performance Physical Therapy of Idaho. Please complete the following forms. Please Print Clearly.

Patient's Name: _____ Today's Date:_____

Address:_____ City:_____St:____Zip:_____

SSN (Billing purposes): _____ Sex: M F Date of Birth:_____

Driver's License Number: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Email Address: _____

Occupation:_____ Employer:_____

Injured Body Part: _____ Date of Injury/Surgery:_____/_____/_____

Referring Doctor: _____ How did you hear about us?_____

Are you under 18 and/or a dependent on a guardian's insurance (circle one)? Yes No

If Yes, Guardian's Name: _____

Emergency Contact:_____ Phone: ( ) _____

Insurance/Billing Information

Please Provide Performance Physical Therapy of Idaho with your Primary and Secondary health insurance information and a copy of your insurance card(s).

Name of Insured:_____ Relationship to Patient: _____

Is this a work related injury? Yes No **If Yes,** Worker's Compensation Claim:_____

Worker's Compensation Adjuster: _____ Adjuster Contact #:_____

If No, Primary Insurance Provider: _____ Policy Number: _____

Group Number: _____ Services Contact Number: ( ) _____

Secondary Insurance Provider: _____ Policy Number: _____

Group Number: _____ Services Contact Number: ( ) _____

I certify the above information is true to the best of my knowledge. I will notify you of any changes in the above information.

Patient's Signature:_____ Date:_____

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

Release of Information / Financial Policy

Please remember to bring your picture ID and insurance cards.

Thank you for choosing Performance Physical Therapy of Idaho as your health care provider. Following is a statement of our Release of Information/ Financial Policy, which we require you to read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

Release of Information/ Medical Records Initials _____
By signing this form, you authorize Performance Physical Therapy of Idaho to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations- 42CFR Part 2. You agree that a photocopy of your original authorization shall be considered equally authentic.

Regarding Insurance Initials _____
We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to Performance Physical Therapy of Idaho for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays due at the time of service. Your insurance policy is a contract between you and your insurance company. If your insurance plan changes during the course of your treatment, it is your responsibility to notify us of that change before it occurs. If you have received physical therapy at another facility during this year, it is your responsibility to notify us of that as well. If you fail to do so, you will be responsible for any unpaid portion of your bill. ***Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.***

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. **In the event that your account becomes past due and is turned over to collections, you will be responsible for all cost of collections, including collection agency expenses and fees not to exceed 50% and all cost to file suit including attorney fees and court costs.**

Those Insurance Plans in which we are a Participating Provider.
All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance
coverage changes to a new plan in which we are not a participating provider, refer to the paragraph below.

Those Insurance Plans in which we are NOT a Participating Provider.
If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

Please Note: If any payment is made directly to you for services billed by Performance Physical Therapy of Idaho, you recognize an obligation to promptly remit the amount received back to Performance Physical Therapy of Idaho.

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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. You are responsible for payment unless we are a participating provider for your insurance company.

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.

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.

By my signature**, I consent to receive Physical Therapy treatment** as prescribed by my physician and given by a qualified licensed Physical Therapist. This consent is intended as a waiver of liability for such treatment, except in acts of negligence. 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

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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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HIPAA Consent Form

This consent form allows Performance Physical Therapy of Idaho to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment, research or healthcare operations.

Performance Physical Therapy of Idaho has offered me a Notice of Privacy Practices, which more completely describes such uses and disclosures. They offered this notice to me prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting Performance Physical Therapy of Idaho and requesting a current copy of the Notice of Privacy Practices.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment, and health care operation. I understand that while Performance Physical Therapy of Idaho is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Performance Physical Therapy of Idaho may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that Performance Physical Therapy of Idaho may refuse me services if I refuse to sign this consent.

Print Name_____

Signature_____

Date_____

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