



Care at its Best!
www.performanceptri.com

Patient Information

Name: _____ Date of Birth: _____

Age: _____ SSN#: _____ Email: _____

Home Phone No: (____) _____ Cell Phone No: (____) _____

Address: _____

If you are a Minor, Guardian Name and Relation to you: _____

Chose clinic because/referred by (please check those that apply): Dr Insurance Plan Hospital

Family/Friend Yellow Pages Location Internet Other _____

Work Status (please check): FT PT Disabled Retired Unemployed Other _____

Employers Name: _____

Address: _____

Telephone: _____ Your Occupation: _____

Health Insurance Information

Primary: _____ **ID Number:** _____

Please complete *if you are not the subscriber*:

Subscribers Name: _____ Date of Birth: _____

Relation to you: _____ SSN#: _____ Employer: _____

Secondary: _____ **ID Number:** _____

Please complete *if you are not the subscriber*:

Subscribers Name: _____ Date of Birth: _____

Relation to you: _____ SSN: _____ Employer: _____

Physician

Name & telephone of Referring Physician: _____

Name & telephone of Primary Care Physician: _____

Complete Only if injury is Workers Comp, Auto Accident or Attorney is involved

Injury Type (please circle): Work Related / Auto Accident / Slip or Fall

Injury Date: _____ State that Accident/injury occurred: _____

Employer's Worker's Comp Carrier: _____

Supervisor/Contact Person at Work: _____

Attorney: _____ Telephone: _____

Address: _____

Cancellation Policy

Missing an appointment hinders your recovery and disrupts the schedule of your therapist. In the case that you need to cancel or reschedule please call at least 24 hours before you appointment.

There will be a \$25 charge for missed follow up appointments, without 24 hour notice.

Financial Policy

Please note that you are responsible for the payment of services rendered by Performance Physical Therapy. We will do our utmost to assist in gathering information regarding claims, but it is your responsibility to know your benefit and coverage limits.

Payment is due at the time of services for co-payments and services not covered by your insurance company. Any balance due more than 30 days shall accrue interest at a rate of 1 1/2% per month until paid. Unpaid balances will be referred to a collection agency.

Consent to Treat

The undersigned, authorizes Performance Physical Therapy to complete a Physical Therapy evaluation and to administer treatment that is necessary and appropriate.

Acknowledgement of Terms

By signing below, I attest that all information is true and correct. I have read, understood and accept the polices stated above.

Patient signature: _____ Date: _____

Patient Care Coordinator: _____ Date: _____

Notice of Privacy Practices

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

Patient Signature: _____ Date: _____

For office use only – in the case that acknowledgement not obtained.

Patient Refused Other _____

Signature and Date: _____

***Thank you for Choosing Performance Physical Therapy
Physical Therapy Care at its Best!***