CORE PERFORMANCE
PHYSICAL THERAPY

Name: **Today's Date:**

Address:

City: **State:** **Zip Code:**

Date of Birth: **Gender:** **Status:** Single/Married/Widowed

Driver's License: **Occupation:**

Social Security:

Home Phone: **Mobile Phone:** **Work Phone:**

Email:

Do you prefer to receive email, text or phone reminders?

Emergency Contact: **Phone Number:** **Relationship:**

Do you authorize Core Performance to disclose medical information to the above email address and emergency contact? Y N

Referring Doctor:

Surgical History (*please specify dates*):

Do you have your Imaging Reports in hand? Y N **Do you have a pacemaker?** Y N

List of Current Medication (*for Medicare patients please complete page 6*):

Previous Medical Conditions:

Have you had any physical therapy this current year? Y N **Are you currently receiving Home Health Care?** Y N

Who can we thank for referring you?

a) Doctor's office b) Family or friend c) Yelp/Google d) Instagram/Facebook e) Other

If you selected family or friend, please specify who: _____

We look forward to helping you recover!

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In order to optimize your therapy, we ask that you please do the following:

- Arrive on time for your appointment. If you are going to be more than 15 minutes late to your appointment, please call us to reschedule.
- Please sign in for treatment each day.
- Please familiarize yourself with the 24-hour cancellation policy (*refer to the section below*).
- Please schedule ahead; 6-10 visits to ensure your preferred appointment time and continuity of care.
- Wear loose fit clothing appropriate for exercise. Please do not wear jeans, dress shirts, skirts which can make treatment difficult.
- Please leave food and beverages outside of the clinic (you may bring your own bottle of water).
- Please wash your hands and feet before treatment (if you are a foot/ankle patient).
- Please remove your shoes while on the treatment tables and equipment.
- Please turn off your cell phones.

Cancellation/No Show Policy

A 24-hour notice is required in the event of a cancellation or a no show. **Failure to provide such notice will result in a charge of $100.00 (for day-of cancellation or no show) on initial evaluation visits and $50.00 (for day of cancellation) and $75.00 (for no show) on follow-up visits.** This charge will NOT be covered by your insurance; rather it will be billed directly to the patient.

We do our best to remind you of your appointments however, scheduling and cancelling appointments is ultimately your responsibility. Failure to do so will result in the above referenced charges.

Credit Card Information

Please provide a credit card below. Core Performance Physical Therapy will keep this information encrypted in our system. **It will only be used for patient balance and in case Cancellation or No Show fees apply.**

ALL SALES ARE FINAL and we do not accept American Express cards.

Name on Credit Card: _____ Select Card Type: _____VISA___/___MasterCard_____

Credit Card Number: _____ Exp. Date: _____ 3-Digit Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip Code:_____

The above information has been explained to me. I authorize Core Performance Physical Therapy to use the above credit card information to charge my patient balance and in the event of a late cancellation or no show.

_____

Patient /Parent/Guardian Name (Print Name)

_____

Patient/Parent/Guardian Signature *Date*

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CONSENT FOR CARE AND TREATMENT OF A PATIENT. The physical therapist assigned to your initial examination will complete an evaluation and design a treatment protocol customized to your current condition. A variety of treatment techniques may be used during your physical therapy sessions.

We at Core Performance recommend a team approach to your physical therapy needs. A multi-therapist approach allows us to offer you broader clinical backgrounds along with different professional expertise to help you reach your goals quickly and safely. This also ensures more flexibility with scheduling appointments. Please be reassured that all our physical therapists share a similar philosophy and that your present therapist puts together a plan of care that can be carried out by any of the other therapists at Core Performance Physical Therapy. If you are only willing to work with one physical therapist, we will do our best to accommodate your needs.

SCHEDULING, EXPECTATIONS AND COMPLEMENTARY DISCIPLINES. We typically schedule appointments over the phone or in person. We ask that our patients provide us with a verbal or written consent before booking an appointment date and time. By providing us with your broadest availability, we will try our best to accommodate your requests.

Following your first physical therapy appointment, please expect some muscle soreness at and around your treated body part. The soreness is a result of activating muscles that have been inhibited by injury and stimulating injured soft tissue. We strongly recommend good hydration and ice application to your areas of discomfort and soreness. If you experience any unrelenting pain, please call us and we will redirect you to a therapist.

We at Core Performance believe that physical therapy can be complemented with Massage Therapy, Personal Training and Pilates Training for optimal results. We also offer a Golf Performance Training for those who want to return to their golf game. These complementary disciplines will assist you with a quicker turnaround time getting you back to your prior level of function. We encourage you to ask our front desk for more information on any of the above that might interest you.

I, the undersigned, hereby agree and give consent for Core Performance Physical Therapy to provide physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition.

_____

Patient's Name (Print Name)

_____

Patient's Signature *Date*

As parent and/or legal guardian, I authorize Core Performance Physical Therapy to treat the minor patient named in the attached forms while I am not present.

_____

Parent/Guardian's Name (Print Name)

_____

Parent/Guardian's Signature *Date*

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Insurance and Financial Policy

- As a courtesy to our patients with health insurance coverage, we contact your insurance carrier to obtain authorization and verification of your coverage. We will provide you with an estimate of the out of pocket cost that you may expect during your treatment.
- Please understand that this is only an estimate and your insurance company ultimately determines the amount you will be liable for at the time claims are processed.
- Co-pay, co-insurance and deductible amounts are due at the time of service unless prior arrangements are made with Core Performance Physical Therapy.
- In the event that your insurance company denies your claim, you understand that you are liable for the full cost of treatment.
- We strongly encourage you to contact your insurance company at the start of your treatment to verify that the benefits provided are correct.
- If you find discrepancies with our information or have any questions concerning your coverage, please contact us immediately.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Core Performance Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKER'S COMPENSATION: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for serviced rendered to you.

MOTOR VEHICLE ACCIDENT. If your injury is related to a motor vehicle accident and your private health insurance denies your claim, you are responsible for the total amount of charges billed.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balanced owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in the quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

_____

Patient/Parent/Guardian Signature *Date*

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Notice of Privacy Practices

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. **FOR PAYMENT**: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or third party. **FOR HEALTH CARE OPERATIONS**: We may use and disclose health information about you for operations of our heath care practice. **FOR INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE**: We may release medical information about you to a friend or family member who is involved in your medical care. **FOR HEALTH-RELATED SERVICES AND TREATMENT ALTERNATIVE**: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **AS REQUIRED BY LAW**: We will disclose medical information about you when required to do so by federal, state or local law. **TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY**: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **FOR MILITARY AND VETERANS**: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **FOR WORKER'S COMPENSATION**: We may release medical information about you for workers' compensation or similar programs. **FOR PUBLIC HEALTH RISKS**: We may disclose medical information about you for public health activities. **FOR HEALTH OVERSIGHT ACTIVITIES**: We may disclose medical information to a health oversight agency for activities authorized by law. **FOR LAWSUITS AND DISPUTES**: If you are involved in a lawsuit or a dispute. We may disclose medical information about you in response to a court or administrative order. **FOR LAW ENFORCMENT**: We may release medical information if asked to do so by law enforcement officials. **FOR CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS**: We may release medical information to a coroner or medical examiner. **FOR NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES**: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **FOR PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **FOR INMATES:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To Inspect and copy of your medical information, you must submit your request in writing. We may deny your request to Inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **YOUR RIGHT TO AMEND:** If you feel that medical information we have about you is incorrect or incomplete, you may request and amendment in writing. **YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES**: You have the right to request in writing, a list accounting for any disclosures of medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **YOUR RIGHT TO REQUEST RESTRICTIONS**: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS**: You have the right to request in writing that we communicate with you about medical matters in a certain way or at certain location. **YOUR RIGHT TO A PAPER COPY OF THIS NOTICE**: You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices

_____

Patient/Personal Representative Signature *Date*