Name: Date:

Patient Name: _____ Gender: Male / Female

Date of Birth: _____ Email: _____

Mobile: _____ Home: _____

Yes ____ No ___ [I agree to allow Champion Performance to send me automated text messages to the number I have provided for appointment reminders.]

Address: _____

City: _____State: _____ Zip: _____

Primary Insured: _____DOB: _____

RESPONSIBLE PARTY - BILLING

Name: _____ SSN: _____

Address (where to mail bill): _____

City: _____State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

CURRENT INJURY

Referring Doctor: _____ Date of Injury: _____

Surgery: _____ Date of Surgery: _____

Name: Date:

1) Recent diagnostic studies (X-rays, MRI, CT Scan)? If so, please provide us a copy or we can request one from the doctor that performed the exam.

2) List any medications you are currently taking:

3) Describe Injury:_____

4) Where is your pain: _____

5) Pain Today: _____ (0-10, 0 = no pain 10 = Worst Possible)

6) Duration of Pain (circle one): Constant (all the time) / Intermittent (comes and goes)

7) Pain Level (On a scale of 0-10):

At Rest _____ W/ Activity _____ Worst _____ Least _____

8) Character of Pain (check those that apply):

__ Aching
__ Burning
__ Cramping
__ Dull
__ Electrical
__ Heavy
__ Localized
__ Radiating
__ Sharp
__ Shooting
__ Stabbing
__ Tender
__ Throbbing
__ Tiring
__ Other: _____

MAKES PAIN WORSE (EXACERBATING)	YES	NO	MAKES PAIN WORSE	YES	NO
Bending Forward			Coughing/Sneezing		
Household Chores			Lifting (If Yes, Circle One) 5lbs – 10 – 20 – 50 – 100		
Reaching Away from Body			Reaching behind Back		
Sitting (If Yes, Circle One) Length of Time in Mins: 10 – 30 – 60			Standing (If Yes, Circle One) Time in Mins: 10 – 30 – 60		
Standing up from Sitting			Walking (If Yes, Circle One) Distance: ¼ mile – ½ – 1		
Other (Circle one below): Sleeping – Driving – Sports - Stairs - Squatting			Other (write your own):		

Name: Date:

MAKES PAIN BETTER (RELIEVING)	YES	NO	MAKES PAIN BETTER	YES	NO
Exercise Programs / Sports			Heat		
Ice			Lying Prone (on your stomach)		
Lying Supine (on your back)			Massage		
Medication			Resting		
Standing			Walking		
Other:					

MEDICAL HISTORY

Have you ever had (if yes, please explain):

ISSUE	YES	NO	EXPLAIN
High Blood Pressure			
Heart/circulation Disorders			
Seizures			
Dizzy Spells/Vertigo			
TMJD			
Cancer			
Osteoarthritis			
Osteoporosis/Osteopenia			
Rheumatoid Arthritis			
Autoimmune Disease			
Diabetes			
Strokes			
Nervous Disorders			
Allergies			
Other			

1) Previous Surgeries?

2) For women, are you pregnant? NO / YES

3) Have you had unusual weight loss/gain recently? NO / YES

4) Have you taken steroids or anti-coagulants for an extended period of time? NO / YES

5) Do you have abnormal trouble with (not including prescription lenses):

Vision – NO / YES If yes: _____

Hearing – NO/YES If yes: _____

Name: Date:

INSURANCE

Primary Insurance

Provider: _____ ID: _____ Group #: _____

Subscriber/Primary: _____ Date of Birth:_____

Relationship to Patient: _____

Secondary Insurance

Company Name: _____ Patient ID #: _____

Additional Information:

Workers Comp

Adjuster Name: _____ Phone #: _____

We will only bill your primary insurance, listed above, unless you provide information for a secondary provider or worker's comp. This includes secondary insurances provided through school or athletic organizations.

Cash Pay Rates

Evaluation = $130 Daily = $100

It is important you understand that you are personally responsible for all services rendered at Champion Performance Physical Therapy and that all fees are charged directly to you. As a courtesy, we will bill your insurance if you provide us with the appropriate information. Please allow us to make a copy of your insurance card and photo ID for your file. We advise you to contact your insurance company and inquire specifically about your physical therapy benefits. You also understand you have been given an estimate of what your financial responsibility will be and that this is only an estimate based on the information given to the Champion Performance Physical Therapy staff by your insurance company.

With my signature, I consent to receiving physical therapy treatment. I also hereby authorize the release of medical information necessary to process the claim and authorize the payment of medical benefits to Champion Performance Physical Therapy.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Name: Date:

MEDICAL RELEASE

At CHAMPION PERFORMANCE PHYSICAL THERAPY, we have always kept your health information secure and confidential. We may disclose necessary health information for usual healthcare operations (payment of services, to contact you, physician, insurance carrier, etc.) or as required by law. We will not disclose your health information beyond the normal uses. A full notice of how your health information may be used and disclosed and how you can access or restrict this information is posted in our office and a copy will be made available to you upon request.

Champion Performance Physical Therapy is an open treatment facility. All therapists and staff members will use discretion during treatment but other patients, patient's family members and staff will be within close proximity. By signing this form you are agreeing to treatment in an open facility and understand that treatment may occur alongside other patients.

DIAGNOSIS & TREATMENT

I, ☐Do ☐Do not want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

1.

2.

3.

Please sign to acknowledge that you understand CHAMPION PERFORMANCE PHYSICAL THERAPY'S privacy practices.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date:_____

Name: Date:

PAYMENT AND BILLING POLICY

Thank you for choosing **Champion Performance Physical Therapy**. As a courtesy, we will contact your insurance provider to verify eligibility and benefit information. ***This verification is not a guarantee of benefits or payment. You should also contact your insurance company to request your physical therapy eligibility and benefits.*** It is your responsibility to understand your insurance policy, which is a contract between you and your insurance provider.

Insurance: We will submit bills to most insurance companies on your behalf, and will assist in maximizing your insurance benefits. However, you are responsible for payment of all charges, including deductibles, co-insurance, co-payments and any and all denied charges. We will bill you monthly as we receive payments from your insurance company. Insurance **co payments** are due at the time of service.

Payment: If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full by you. Payment for charges we have billed to you is due within 15 days of the date on your bill. **For those without insurance,** payment in full is expected at the time of service. We accept cash, check, and most major credit cards.

Returned Checks: Checks returned to the bank for insufficient funds will be subject to a fee of **$25.00**.

Collections / Legal Costs: In the event that your account is forwarded to collections, you are responsible for any collection fees incurred by **Champion Performance Physical Therapy.** If it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for our incurred costs and/or court fees, in addition to your outstanding balance.

Medicare: We accept Medicare assignment. Please provide us with any secondary insurance information you may have. You will be responsible to pay any applicable co insurance, deductibles, and all Medicare allowable unpaid balances on your account. We will provide you with assistance and information regarding current Medicare policies.

Liens/MVA's: We do not accept liens and cases of motor vehicle accidents.

Referrals: A written prescription for physical therapy is required by the State of Texas. If a primary care physician's referral or a written prescription is required by the health insurance company, it is the patient's responsibility to provide us with this referral and any subsequent referrals needed for further treatment. We will assist you as much as possible with this process. If a referral is not obtained prior to your first visit and insurance denies payment, you will be held responsible for payment in full.

Financial Agreement/Assignment of Benefits:

I authorize payment of medical benefits as determined by the Insurance Company directly to **Champion Performance Physical Therapy**. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of me and/or dependents. As a patient or legal guardian, I understand I am responsible to pay for all services rendered in accordance with the terms and conditions set forth in this policy. Any money paid to me by my insurance company for services rendered and billed by **Champion Performance Physical Therapy** shall be paid to **Champion Performance Physical Therapy** immediately upon receipt. My signature on this form indicates that I have read, understand and agree to the policies of Champion Performance Physical Therapy.

_____ _____

Signature of Responsible Party Date

Name: Date:

PATIENT APPOINTMENT POLICY

We strive to provide our patients with the highest level of care. We are committed to helping you through every step of the therapy process in order for you to achieve your goals. To do so we ask that you adhere to our patient appointment policy outlined below. This allows our therapists to create an ideal environment for all patients and ensure that you and other patients are able to be treated according to your plan of care.

It is expected that you attend all scheduled appointments unless you are able to reschedule or cancel your appointment the day before. You may cancel your appointment by speaking with someone in person, over the phone or you can leave a voicemail.

RESCHEDULING GUIDELINES

YOU MUST CANCEL/RESCHEDULE BY:

The day before your scheduled appointment. The more notice you give us the more likely we are to get you rescheduled into a time that works for you.

HOW TO CANCEL OR RESCHEDULE:

Call the office and speak to a live agent or leave a voicemail.

DAY OF CANCELS AND NO SHOWS WILL BE CHARGED:

$60

We understand that family emergencies, work/school conflicts and illness can occur and reserve the right to charge for late cancels as we deem necessary. We appreciate you choosing Champion Performance for your physical therapy needs and strive to be a family friendly company, while still respecting the time and schedules of our therapists.

I HAVE READ THE POLICY AND AGREE TO BE CHARGED THE LATE CANCEL AND NO SHOW FEE IF I DO NOT CANCEL IN THE APPROPRIATE AMOUNT OF TIME.

Signature: _____ Date: _____

Name: Date:

FOR OFFICE USE ONLY

Case Name:

Diagnosis:

Diagnosis Codes:

Functional Scales:

Referring Physician: **Direct Access: _____**

Call for: **Protocol _____ MRI Report _____ RX _____**

OBJECTIVE MEASURES

DOI: DOS: MOI:

PAIN (current):
Best = Worst =

ROM:

STRENGTH:

SWELLING:
GAIT:
BALANCE:

SOFT TISSUE:

OTHER:

PT _____ ENTERED _____ SCANNED _____