PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	Account#		Account Type:		
First Name:		MI:	SSN:		
Last Name:		Date of injury/Onset:			
Address:		Date of Birth:		Age:	
City:	State:	Zip:	Sex: _M _ F		
Home Phone:		Marital Status: _Single _Married			
Cell Phone:		_Divorced _Widowed			
Email:		Injury Area:			
Employer:		Occupation:			
Address:		Contact:			
City:	State:	Zip:	Phone Number:		
Referring Physician:			Phone Number:		
Emergency Contact		Phone Number:			
Are you receiving or have you recently received home health services? _Yes _No					
Are you receiving or have you recently received other therapy services? _Yes _No					
How did you hear about us?					
Primary Insurance:		Insured Name:			
ID#	Address:		City:		
Group#	State:	Zip:	Phone:		
Relationship to insured:		Insured Date of Birth:			
Responsible Party:					
Address:					
City:	State:	Zip:			
Phone Number:					
Relationship to responsible party:					

CONSENT TO PHYSICAL THERAPY

(PLEASE READ BEFORE YOU SIGN)

1.CONSENT TO TREATMENT: I consent to rehabilitation and related services at PerformaX Physical Therapy. In doing so, I understand, Acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

2.TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

3. LIABILITY: I know and agree that PerformaX Physical Therapy is not responsible for loss or damage to personal valuables.

4. WAIVER AND RELEASE: I hereby release, discharge and acquit PerformaX Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physical or urgent care services.

5. AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to PerformaX Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be responsible for payment.

I certify that all of the information provided herein is true and correct. Date_____

Patient/Guardian Signature_____

Witness Signature_____

MEDICAL HISTORY FORM

Are you presently working? _Yes _No
Have you experienced these symptoms before? _Yes _No (if yes, when?)_____

Indicate how you sustained this condition:

_Work related injury _Athletic/Recreation injury _Cause unknown
_Motor vehicle accident _Injury related to lifting _Recurrence of prior condition
_Other:_____

Have you had surgery related to this condition? _Yes _No
If yes, what type of surgery?_____ Date of Surgery:_____

Are you presently taking medication? _Yes _No
If yes, please list and specify condition(s)_____

What specific activities are you having difficulties with?_____
What personal goals do you hope to achieve from physical therapy?_____
_____
Have you had any physical therapy, occupational therapy, or chiropractic care for this condition?
_Yes _No If yes, please explain_____

PLEASE CHECK IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING:

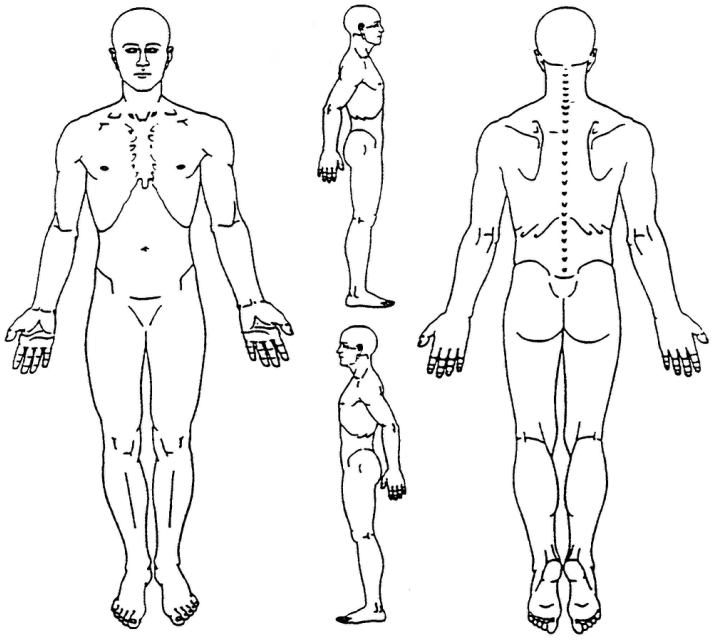
_Alzheimer´s
_Cardiovascular Disease
_Cauda Equina Syndrome
_Cerebral Vascular Accident
_Current Infection
_Diabetes Mellitus Type 1
_Diabetes Mellitus Type 2
_Fibromyalgia
_Fracture or Suspended Fracture
_High Blood Pressure
_History of Cancer
_Huntington´s
_Immunosuppression
_Lupus
_Muscular Dystrophy
_Obesity
_Osteoarthritis
_Parkinson´s
_Rheumatoid Arthritis
_Traumatic Brain Injury
_Other: _____
_____

If you answered "yes" to any of the above, please explain and give approximate dates:_____
_____
Please list any other surgeries you have had in the last 5 years, including type and date:_____
_____
Do you participate in any sports, exercise, or engage in strenous activities on a regular basis? _Yes _No
If yes, please describe:_____
Is there any other information regarding your past medical history that we should know about?
_____

Patient/Guardian Signature:_____ Date:_____

MEDICAL HISTORY FORM - CONTINUED

Please indicate where your symptoms are located:



Please circle the appropriate number that best describes your pain level:

0	No pain
1	Mild Pain, you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication
4 to 5	More severe pain; you begin to reduce your activity level
6	Severe pain
7 to 9	Intensely severe pain
10	Most severe pain: it may require a visit to the emergency room

Breifly describe your injury:_____
_____
_____
_____

Patient/Guardian Signature_____ Date_____

Therapist Signature_____ Date_____

FINANCIAL POLICY

Thank you for choosing PerformaX Physical Therapy as your Physical Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.

Payment of services is due prior or upon completion of each treatment visit. We accept CASH, MASTERCARD, VISA, DISCOVER, or PERSONAL CHECKS. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

_____INITIALS

Insurance

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and/or the insurance company. We are not a part of that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered.

It is our policy to verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At that point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make proper adjustments to your claim.

_____INITIALS

Non-covered Expenses

Our practice is comitted to providing the best treatment for our patients and we charge what is usual and customary for our area.You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

_____INITIALS

Electrodes: Upon the initial evaluation your Physical Therapist may determine that it would be beneficial for you to receive electrical stimulation as part of your treatment plan. It is our recommendation to purchase personal electrodes at the cost of $10 that will be kept at the clinic for your individual use. Should you choose not to purchase personal electrodes; the clinic will provide shared electrodes(It is mandatory that you purchase personal electrodes if you have open incisions, wounds, or any infectious disease).

__ I would like to purchase personal electrodes at a cost of $10.00 _____INITIALS

__ I would like to use the clinics shared patients electrodes _____INITIALS

Credit Card Hold

PerformaX requires a credit card to have on file. This card will NOT be charged at this time. It will only be used for mentioned non insurance covered items or if you fail to give us a 24 hour cancellation notice (see missed appointment policy). You will be notified before any such charges are made. If you are unable to secure your appointment, we offer SAME DAY SCHEDULING depending on availability.

Credit Card Type: ☐ VISA ☐ MASTERCARD ☐ AMEX

Credit Card Number:_____

Exp Date:_____ CCV Code:_____

Billing Zip Code for Credit Card:_____

Notices

In order to insure safety and quality of care please take note of the following: Please arrive on time for your appointment, time is deducted from your treatment time if you are over 15 min late. Small Children not being treated at our facility must not be left unsupervised, please make an effort to find a sitter to allow you and your treating provider to focus on your treatment. Please wait to be called into the treatment area behind the front desk, only treating patients, staff, and authorized personel are allowed in the clinical area. Please wear sport clothing or gym friendly attire to accomodate your injured area. Parking is located ONLY directly behind our building, or down the street at 2111 West Alameda Ave.

PATIENT INFORMATION CONSENT FORM

Information

I give my permission to PerformaX Physical Therapy to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, or other assignees as it relates to my treatment. I further authorize PerformaX Physical Therapy to obtain medical records from my physician or other medical professionals as it relates to my treatment

INITIALS

I have read, understand, and agree with this Consent Form.

Patient/Guardian Signature_____ Date_____

Witness Signature_____ Date_____

DISCLOSURE AUTHORIZATION - FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that PerformaX Elite may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any adminstrative operations related to treatment or payment. I understand that I have a right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in PerformaX Elite's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient's Name:_____ Date_____

_____Initials

Communication of health Information

I give permission to PerformaX Elite to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Signature_____ Date_____

2001 W. Alameda Ave. Burbank CA 91506

MISSED APPOINTMENT AND CANCELLATION NOTICE POLICY

Sessions that are scheduled in advance are reserved exclusively for the client. When a session is cancelled without adequate notice, the therapist is unable to fill this time slot by offering it to another "wait listed" client. PerformaX Physical Therapy is also unable to bill your insurance company for sessions that are not kept.

Please note, a fee of $65 will be charged when a client misses or cancels an appointment without giving 24 hours notice. This means that if an appointment is scheduled for 3 pm on a day, notice must be given by 3 PM the previous day. You can cancel your appointment by calling PerformaX Physical Therapy at 818-953-4444 or emailing us at performax@pmxpt.com. Do not reply to text or email reminders, these are automatic and do not receive responses. **NO fee will be assessed if we receive appropriate notice.**

Missed appointment fees will be automatically charged to the credit card on file, following a 24-hour grace period from the date of the scheduled appointment. This 24-hour grace period allows the client to be able to get in touch with PerformaX to discuss the reason for the missed appointment. During the grace period, the client can choose to pay the fee with another form of payment other than the credit card on file or if necessary, set up a payment plan. If the client does not contact PerformaX to make other payment arrangements within 24 hours, the credit card on file will be charged. **IF PAYMENT FOR THE MISSED APPOINTMENT HAS NOT BEEN SATISFIED, ALL FUTURE APPOINTMENTS ON THE CALENDAR WILL BE CANCELLED AND ALL FUTURE VISITS WILL BE BOOKED VIA OUR SAME DAY APPOINTMENT SCHEDULING FEATURE (see below).** We'll do everything possible to respect your time. Please respect ours!

SAME DAY APPOINTMENT SCHEDULING

Some of our clients have circumstances that make it difficult for them to adhere to a planned schedule. Because of this, we have created a Same Day Appointment Scheduling feature. Call us the evening before or the day that you would like to be seen, and we'll try our best to get you on the schedule. At the worse, we'll waitlist you and get back to you if a time becomes available. Please understand that though your treatment plan will remain unchanged, utilizing this feature means that specific treatment times and doctor availability will be variable.

I have read and fully understand my responsibility to advise PerformaX Physical Therapy of any cancellation within 24 hours. I accept this policy and authorize PerformaX Physical to charge my credit card on file $65 in the event that I fail to follow this procedure.

Patient's Name: _____

Signature: _____Date: _____

Social Media Publication and Consent Form

I hereby consent to release for possible publication my photo(s) and /or video images taken by any authorized PerformaX Physical Therapy or elite employee/agent (which includes PMX Golf & In.form products), or any media representative for news and/or publicity purposes. This may include television, newspaper, magazine article, social media sites (Instagram, Facebook, Twitter, Yelp, etc.) and/or PMXPT publications (newsletters, flyers, brochures, World Wide Web Page, etc.). I understand that I will not receive payment for my voluntary participation or future use of any photo(s) and/or images of me. I understand that photos and /or videos for the media and /or World Wide Web may be used in publications and /or Web sites outside of PMXPT's control.

Client's Name_____ Client's Signature_____

Date_____

2001 W. Alameda Ave
Burbank CA 91506
Phone: 818 953 4444 Fax: 818 953 4940