PATIENT INFORMATION

First Name | Last Name | MI

Mailing Address

City | State | Zip Code

Cell Phone | Home Phone | Work Phone

DOB | Age | Sex ❍ Female ❍ Male | SSN#

Marital Status ❍ Married ❍ Single ❍ Divorced ❍ Widow ❍ Domestic Partner

Email Address

Employer Name | Occupation

Is this injury work-related? ❍ Yes ❍ No | Is this injury related to an auto accident? ❍ Yes ❍ No | Do you have Medical Insurance? ❍ Yes ❍ No

Do you have Medicare? ❍ Yes ❍ No | Is this injury related to a Workers' Comp claim? ❍ Yes ❍ No

In case of emergency, please notify: Name | Phone | Relationship

Responsible for payment (if other than patient; i.e., Parent, Spouse, Guardian): Name of Responsible Party

Mailing Address of Responsible Party

City | State | Zip Code

Cell Phone | Home or Work Phone

Name of Medical Insurance Company (PRIMARY)

Name of Medical Insurance Company (SECONDARY)

Policy Holder Name | Policy Holder DOB

Referring Physician

2001 W Alameda Avenue • Burbank CA 91506 • P (818) 953 4444 • F (818) 953 4940 • www.pmxpt.com
Email: PerformaX@pmxpt.com

PerformaX elite

MEDICATION RECORD					
Medication / Vitamin / Supplement	**Dose / Strength**	**Frequency**	**Form of Medicine** *(Pill, shot, drops, etc)*	**Time of day**	**Is this medication new within the last 6 months?** *(Yes / No)*

I certify that this information is complete and true. I acknowledge that nondisclosure of medicinal information could directly impact my health and services I receive. I further accept full responsibility in updating my therapist should any changes be made to my medicinal regimen.

It's a joint effort in making sure your medication list is current. In the event that your medication changes, please inform us as this information needs to be recorded each visit.

X

Signature Date

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Patient Name: _____

Acct No. _____

HISTORY & PHYSICAL

Name | Date of Birth

Reason for visit

Date of original symptoms/accident/surgery

Describe your symptoms

List any diagnostic testing (X-Ray, MRI, CT)

List any previous treatment of this issue

1 = NO PAIN 5 = MODERATE PAIN 10 = EXCRUCIATING PAIN

Describe your pain (1-10 rating) ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10

Describe your pain: ❍ Constant ❍ Frequent ❍ Occasional ❍ Intermittent

Have your symptoms changed in the last 4 weeks? ❍ Yes, they have improved ❍ No, there has been no change ❍ Yes, they are getting worse

What sports or other activities do you participate in?

List any significant prior surgeries or injuries

Please mark any you the following that you have or have had:

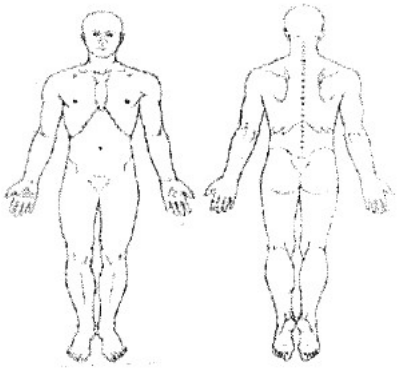
General Health

- ❍ Chest pain (Angina)
- ❍ Heart Attack or Surgery
- ❍ Rheumatic Fever
- ❍ Pacemaker
- ❍ Emphysema, Bronchitis
- ❍ Pregnancy
- ❍ Diabetes
- ❍ Cancer
- ❍ Stroke
- ❍ Osteoporosis
- ❍ Liver Problems
- ❍ Arthritis
- ❍ Artificial Joints
- ❍ Frequent Headaches
- ❍ Epilepsy or Seizures
- ❍ Kidney Problems
- ❍ High blood pressure
- ❍ Reactions to Heat/Cold
- ❍ Metal anywhere in your body
- ❍ Unexplained weakness, weight change, or shortness of breath
- ❍ Immune Deficiency Disease
- ❍ Hernia
- ❍ Dizziness/Fainting
- ❍ Fever/Chills
- ❍ Nausea/Vomiting
- ❍ MRSA or any Infectious Disease
- ❍ Difficulty with bowel & bladder function
- ❍ Problems with vision, hearing, speech
- ❍ Numbness in genital area/anal area
- ❍ Night sweats/night pain
- ❍ Other _____

Mental Health

- ❍ Anxiety
- ❍ Bipolar Disorder
- ❍ Depression
- ❍ Mental Illness
- ❍ Other _____

Please shade in painful areas below



Do you have any allergies? If yes, please list:

I agree that the above information is correct and true to the best of my knowledge.

X _____

Signature Date

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PerformaX Elite Physical Therapy Office Policies & Consent

- **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at PerformaX Elite Physical Therapy. In doing so, I understand, acknowledge, and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of sensitive nature. I understand that in order to assist the clinicians with efficient documentation, your treatment conversations may be recorded by a HIPAA compliant computer software program to assist with dictation and medical records. _____Please initial

- **AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to PerformaX Elite 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. It is the patient's responsibility to resolve outstanding issues with their insurance carrier and receive reimbursement, if applicable. _____Please initial

- **WAIVER AND RELEASE:** I hereby release, discharge and acquit PerformaX Elite Physical Therapy, its agents, representatives, affiliates, employees, or assigns, of any form 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. _____Please initial

- Co-payments, co-insurance, and deductibles are due at the time of service. We accept cash, check, Visa, Discover, American Express and MasterCard. _____Please initial

- If paying by check, and the check is returned for Non-Sufficient Funds or Account Closure, the patient or patient's responsible party will be responsible for the original check amount in addition to a $25 service fee. Once notified, payment must be made within 15 days, or the account may be turned over to our collection agency. _____Please initial

- By signing this form and providing your phone number, you agree to receive SMS from PerformaX Physical Therapy for appointment reminders, rescheduling requests, and answering questions you may send us. Message frequency may vary. Standard Message and Data Rates may apply. Reply STOP to opt out. Reply HELP for help. Consent is not a condition of purchase. No mobile information will be shared with third parties/affiliates for marketing or promotional purposes. See Privacy Policy at: https://pmxpt.com/privacy-policy Patients are also responsible for notifying the front office of any changes regarding mailing address, phone number, and insurance coverage during or after the course of treatment. _____Please initial

- **LIABILITY:** I know and agree that PerformaX Elite is not responsible for loss or damage to personal valuables. _____Please initial

- **LATE CANCELLATIONS & NO-SHOWS:** We require a 24 hour notice to change or cancel a scheduled appointment. We charge **$65** for each missed appointment and/or late cancellation. This charge will not be billed to your insurance company and payment is due before your next appointment. Refusal to comply will result in cancellation of all future appointments and placement on the WAITLIST ONLY list. _____Please initial

- **Workers' Compensation Patients:** While we are not permitted to charge you for missed or late-canceled appointments, **we are required to report all no-shows and cancellations to your case manager or payer**. Missed visits or non-compliance with your prescribed Plan of Care may result in termination of your Workers' Compensation benefits and discontinuation of your therapy. Please make every effort to attend all scheduled appointments, as your participation is essential to your recovery and ongoing claim. If Applicable _____Please initial

- **TREATMENT OF MINORS**: I, as a parent/guardian of a minor receiving treatment at PerformaX Elite Physical Therapy, 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. If Applicable _____Please initial

Patient/Guardian Signature _____Date_____

CREDIT CARD, MISSED APPOINTMENT AND CANCELLATION NOTICE POLICY

Sessions that are scheduled in advance are reserved exclusively for the client to maintain a 1:1, quality session with your Doctor of Physical Therapy or Physical Therapy Assistant. When a session is canceled without adequate notice, the therapist is unable to fill this time slot by offering it to another "waitlisted" 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. For Monday appointments, cancellations must be made before 12pm on **Saturday**, or may be subjected to our cancellation fee. You can cancel your appointment by calling PerformaX Physical Therapy at 818-953-4444 or emailing us at performax@pmxpt.com. Cancellations can ONLY be made by contacting our office directly and **cannot be canceled online**. **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.

Therefore, we require that you provide a credit card to keep on file, which is secure, for incidentals, even if you are not subjected to a fee for your PT visits. If the credit card on file is declined, or our system is not able to charge you for any other reason, and a less than 24 hour cancellation charge is applied, you will be responsible for the payment and our policy stated below will apply to you.

Missed appointment fees will be automatically charged to the credit card on file. We will make an effort to call you if you do not arrive for your scheduled appointment, but fees will be applied by the end of the day. **IF PAYMENT FOR THE MISSED APPOINTMENT HAS NOT BEEN SATISFIED, ALL FUTURE APPOINTMENTS ON THE CALENDAR WILL BE CANCELED 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! We are a small, private business and we want to continue to provide quality, 1:1 services for our clients.

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. You can also schedule appointments online for the same day. At the worst, 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: _____