Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed Gender: ◯ M ◯ F

Current Address: _____ City:_____ State: _____ Zip+4 digits: _____

Permanent Address: _____ City:_____ State: _____ Zip+4 digits: _____

Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____

Email: _____ Hobbies: _____

Occupation: _____ Student: ◯ Full-time ◯ Part-time ◯ N/A

Referring Physician/Specialty: _____ AND/OR Referral Source: _____

Have you ever had foot orthotics? ◯ YES ◯ NO Height: _____ Weight: _____ Shoe size:_____

Are you covered by health insurance? ◯ YES ◯ NO

Policyholder Name: _____ Policyholder Date of Birth: _____

Policyholder Employer: _____ Policyholder ID #: _____

Guarantor : **Same as Policyholder** ☐ if NOT, Name/Relation:_____ DOB: _____

Address: _____

**********Please allow our staff to make a copy of your insurance card **********

Emergency Information: Name/Relation: _____ Phone: _____

Authorization to release information

I hereby authorize The Functional Performance Center to release any information in the course of my examination or treatment to my doctor and insurance company only.

I also authorize the following people to request/receive any protected health information regarding my treatment, payment, and/or administrative operations related to treatment/payment. I understand that the identity of the authorized individuals must be verified before release of information. (i.e. assistants, secretary/receptionist, spouse, coach, attorney, parents (if patient is over 18), etc.) If no one, please put "N/A".

Name/Relation: _____ Name/Relation: _____

_____ _____

Patient or Legal guardian Signature **Date**

Assignment of Benefits

I hereby authorize payment of medical benefits directly to the Functional Performance Center, if any, otherwise payable to me. I understand that I am financially responsible for the charges not covered by this authorization.

_____ _____

Patient or Legal Guardian Signature **Date**

MEDICAL HISTORY QUESTIONNAIRE

1.) What is your reason for seeking treatment (if more than one reason, please list in order of importance)?

_____

_____

2.) Date of injury/surgery/beginning of symptoms? _____

3.) Do you have any problems with:

a. Allergies? ◯ NO ◯ YES: _____

b. Heart Condition? ◯ NO ◯ YES: _____

c. Seizure Disorder? ◯ NO ◯ YES: _____

d. Diabetes? ◯ NO ◯ YES Hypoglycemia? ◯ NO ◯ YES

4.) Are you pregnant? ◯ NO ◯ YES What Trimester? _____

5.) Who is your primary care physician? (first and last name)_____

6.) Have you sought treatment elsewhere for this problem? (i.e. Chiropractic/P.T./Massage/Other)

_____

7.) What are your goals? _____

8.) Is this injury related to a(n): ◯ **N/A** ◯ **Motor Vehicle Accident (MVA)** ◯ **Industrial (Work)**

How did injury occur? _____

Date of injury: _____ Was another party responsible? ◯ YES ◯ NO

9.) Please list any current medications (please **attach list** or allow FPC to make a **copy of list**):

_____

_____

10.) Please list any pertinent family history of medical problems (i.e. mother has osteoporosis; grandfather had knee replacement due to arthritis):

_____

_____

_____ _____ _____

Patient Name (Print) Patient/Guardian Signature Date

2065 SOUTH COTTONWOOD DRIVE, SUITE 1 ▪ TEMPE, AZ 85282
480.968.2020 ▪ F: 480.968.0404 ▪ WWW.FUNCTIONALPERFORMANCE.COM

FINANCIAL/TREATMENT AGREEMENT

It is to my understanding that The Functional Performance Center is billing my medical insurance as a courtesy to me. ***Any funds issued to me by my insurance company will immediately be paid to The Functional Performance Center.***

_____
Initial

I understand that this account is my financial responsibility and if I or my insurance company does not comply with the above agreement, my therapy will be discontinued and payment on my balance will be due in full.

Cancels/No Shows: I understand that I am responsible for the fee of **$50 (per occurrence for Cancelations w/in 24hrs of scheduled appt) OR $75 (per occurrence for No Shows)** if I should miss a scheduled physical therapy appointment, unless I call and cancel at least 24 hours ahead of the scheduled appointment. FPC will take special circumstances into consideration when deciding if you will be charged. Please give us as much notice as possible.

_____
Initial

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed. There are certain inherent risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

The Physical Therapist will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS: For personal safety, do not use any equipment without a staff member present.

_____
Initial

NOTE: Your deductible/co-pay/co-insurance will be collected at each visit unless otherwise stated. It would be in violation of FPC's agreement with the insurance company if your payment is not received at the time of service. If your account has an outstanding balance beyond 30 days, FPC may charge interest on your balance. After we have made our attempts to collect that balance and have had no response or payment from you, we will forward your account balance onto our collection agency at which time you will be responsible for paying the collection fees (25% of your balance due) as well as your outstanding balance.

A $30 Service Fee will be charged on all returned checks.

The information obtained from my insurance company by The Functional Performance Center is only a description of benefits - not a guarantee of payment. I am responsible for any fees not covered by my insurance company.

_____ _____
Patient/Legal Guardian Signature **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of the Functional Performance Center's Notice of Privacy Practices. (You may request a copy of the privacy practices for your records from the front desk staff or print from our website.)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other

_____
_____
_____

_____
Initials Date