Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Time of Initial Appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_ Gender: M F

Mailing Address\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone #** (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Social Security#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last seen by referring provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief description of condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was injury connected with the patient’s place of employment? NO YES Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_

Was injury a result of a motor vehicle accident? NO YES Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_) \_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Other contact Name & Phone # of Someone NOT Sharing Same Residence\_\_\_\_\_\_\_ ( \_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

AND TERMS OF TREATMENT

I heaby consent to the use and disclosure of my health information for treatment provided to me by Champion Peformance and Physical Therapy, further known as Provider, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

AUTHORIZATION TO RELEASE INFORMATION

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Authorized Individual Relationship Phone#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Authorized Indicidual Relationship Phone#

Referring Practioner:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I authorize Provider to send a ‘thank you’ acknowlegement to my referring physician/practioner that identifies me by name.

CONSENT TO TREAT

Knowing that I have a condition requiring treament by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgement of the Provider.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:

I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to the Provider for unpaid charges. I agree to pay Provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is deliquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by Provider in collectin this amount.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:

I consent to allow Provider to release my outpatient treatment records to durable medical equpment suppliers to simplify ordering my durable medical equipment. Specific infoermation disclosed will be a patient information face shee, physician orders and selected infromation to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:

I understand that Provider is committed to providing all of your patients with exceptional care. When a patient cancels without giving enough notice or misses an appointment, that patient prevents Provider from providing care to another patient. A cancellation is considered to be late when the appointment is not cancelled at least 24 hours prior to the scheduled appointment. To encourage timely notification and reduce missed appointments, Provider has adopted the following policy:

First late cancellation: $0 fee

Second late cancellation: $0 fee

Third late cancellation: $0 fee

Fourth: $50.00 + each occurrence after. At provider’s discretion, cessation of further care to the patient can be administered following 3 subsequent cancels/No shows.

I acknowledge that the foregoing fees are **not** covered by insurance and **must** be paid by me prior to the next scheduled visit.

TELEPHONE CONSUMER PROTECTION ACT NOTICE

In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or emails, using an e-mail address I provide to use.

My signature below indicates that I understand the terms of treatment by Provider.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Representative (if a minor)

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Please indicate which of the following you have experienced. All information will be held in the strictest of confidence.

Are you currently taking any medications**? NO YES**

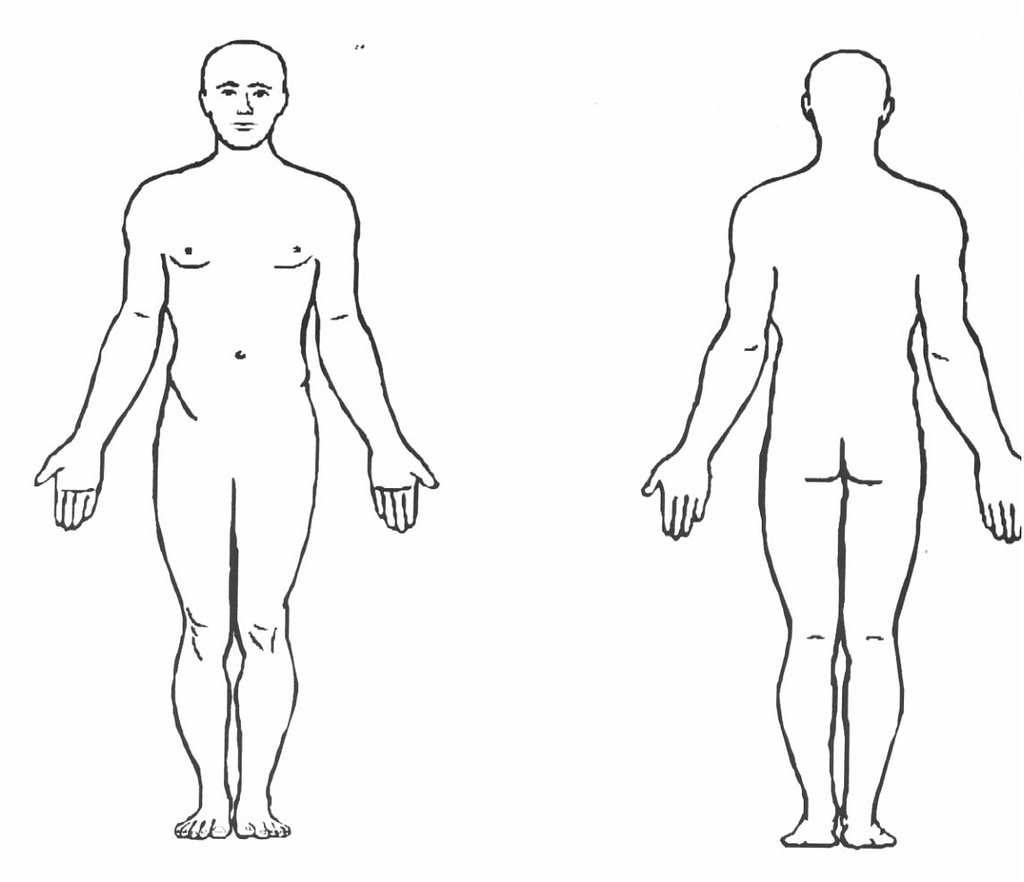
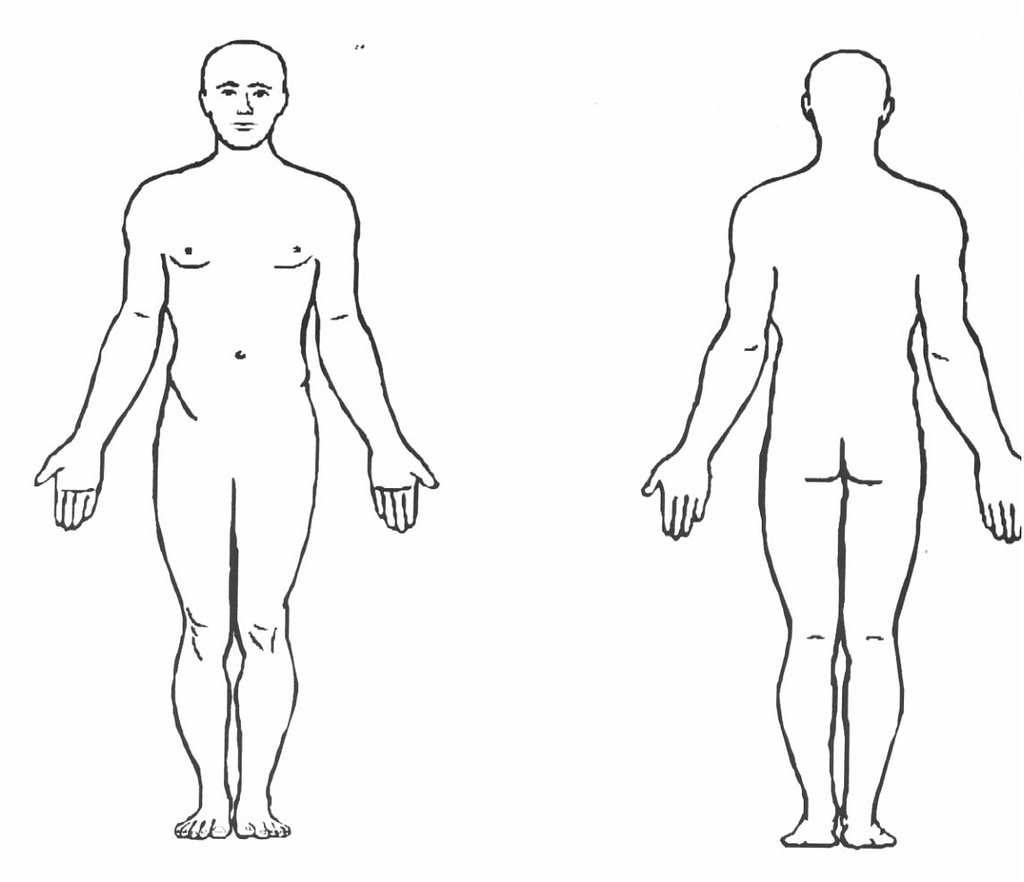
If yes please list :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check only of YES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **YES** | **Date** | **Current limitations** |
| Diabetes |  |  |  |
| Cancer |  |  |  |
| High Blood Pressure |  |  |  |
| Bleeding disorder |  |  |  |
| Raynaud’s/Frostbite |  |  |  |
| Seizures |  |  |  |
| Arthritis |  |  |  |
| Blood Clots |  |  |  |
| Head injury |  |  |  |
| Broken bones |  |  |  |
| Neuromuscular disorder |  |  |  |
| Other |  |  |  |

**\*\*\*\*\*\* SURGICAL HISTORY\*\*\*\*\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **YES** | **Date** | **Type** |
| Joint replacement |  |  |  |
| Orthopedic surgery |  |  |  |
| Heart surgery |  |  |  |
| Lung surgery |  |  |  |
| Fracture reduction |  |  |  |
| Abdominal surgery |  |  |  |
| Spinal surgery |  |  |  |
| Other |  |  |  |

**Rate pain from 0-10 (on an average day)**

(no pain) 0\_\_\_\_\_\_\_\_\_\_\_\_\_5\_\_\_\_\_\_\_\_\_\_\_\_10 (highest)

**Describe your pain using the following symbols:**

**X** (Sharp) **#** (Ache)

**B** (Burning) **=** (numb/tingle)