MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS
East Location: 426A McCall Road, Manhattan, KS 66502
785-776-0670/ Fax 785-776-0096
West Location: 4201B Anderson Avenue, Manhattan, KS 66503
785-539-5555/ Fax 785-539-4551

COMMERCIAL INS. PATIENT REGISTRATION FORM - COMPLETE ALL SECTIONS IN FULL

First Name (Full Legal Name)	Middle Name	Last Name

Sex M ☐ F ☐	Marital Status	Date of Birth	Legal Photo ID#	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	OK to call at Work? ☐

Email Address	Occupation	Employer

NAME OF EMERGENCY CONTACT	Relationship	Address:	Phone #

How May We Contact You? Select All That Apply: Text ☐ Phone ☐ Email ☐ Mail ☐

☐ **(IF APPLICABLE)** I am an established patient with Maximum Performance Physical Therapy & Fitness. There are no changes to my billing information below that I have previously provided.

IF PATIENT IS UNDER 18 OR LIVING WITH PARENT(s)

Father's Full Name	Father's Address	Father's SSN	Father's Phone #
Father's Employer	Employer Address	Father's DOB	Father's Work Phone #
Mother's Full Name	Mother's Address	Mother's SSN	Mother's Phone #
Mother's Employer	Employer Address	Mother's DOB	Mother's Work Phone #

SPOUSE/GUARDIAN/OTHER

First Name	Middle Name	Last Name

Sex M ☐ F ☐	Marital Status	Date of Birth	Legal Photo ID#	Social Security Number

Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	OK to call at Work? ☐

Email Address	Occupation	Employer

CONDITION TO BE TREATED IN PHYSICAL THERAPY:		Date Condition Began

IS THIS VISIT DUE TO AN ACCIDENT OR INJURY?	YES ☐ NO ☐	WORK RELATED?	YES ☐ NO ☐	AUTO?	YES ☐ NO ☐

If yes, provide a brief description of the accident or injury (WHERE DID IT HAPPEN? WHAT HAPPENED?)

DATE ACCIDENT OR INJURY OCCURRED:	
DID THIS CONDITION RESULT IN SURGERY?	YES ☐ NO ☐ IF YES, DATE OF SURGERY
HAVE YOU HAD PHYSICAL THERAPY FOR THIS CONDITION?	YES ☐ NO ☐ IF YES, WHERE
HAVE YOU HAD CHIROPRACTIC FOR THIS CONDITION?	YES ☐ NO ☐ IF YES, WHERE

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PATIENT'S DOCTOR - Please list the doctor who referred you to therapy below

Referring Doctor's Name			Office Phone #	
Doctor's Address	City		State	Zip
Primary Care Doctor's Name			Office Phone #	
Doctor's Address	City		State	Zip

INSURANCE INFORMATION (Copy of Insurance Cards Required)

Patient is the Insured? YES ☐ NO ☐ If NO, complete section below

Insured's First Name (as on Insurance Card)	Middle Name/Initial	Last Name		
Address	City		State	Zip
Home Phone	Cell Phone	Work Phone	OK to call at Work? Y ☐ N ☐	
Sex M ☐ F ☐	Date of Birth	Social Security Number	Legal Photo ID #	Employed Y ☐ N ☐ Retired Y ☐ N ☐ / Unmployed Y ☐ N ☐

Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer's Name			Employer's Phone #	
Employer's Address	City		State	Zip

PRIMARY INSURANCE

Insurance Company Name	Policy ID#	Group #
Street Address	City, State, Zip	Phone #

SECONDARY INSURANCE

Insured is: ☐ Patient ☐ Spouse ☐ Parent

Secondary Insurance Company Name	Policy ID#	Group #
Street Address	City, State, Zip	Phone #

Employer Information (Please complete if the insured person's employer is the source of secondary benefits)

Employer's Name			Employer's Phone #	
Employer's Address	City		State	Zip
Name of Employer Contact			Contact's Phone #	

TERTIARY INSURANCE

Insured is: ☐ Patient ☐ Spouse ☐ Parent

Tertiary Insurance Company Name	Policy ID#	Group #
Street Address	City, State, Zip	Phone #

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PAYMENT AUTHORIZATION - Initials Required for All Statements

ASSIGNMENT OF INSURANCE BENEFITS

I authorize that the payment of my insurance benefits be made directly to Maximum Performance Physical Therapy & Fitness for all services delivered. If I am paid directly I will promptly pay Maximum Performance Physical Therapy & Fitness all monies paid to me.

GUARANTEE OF PAYMENT

I, the responsible party, understand that all payments designated as 'the patient's responsibility' such as co-insurance, co-pays and deductibles are due and payable at the time of service according to Maximum Performance Physical Therapy & Fitness financial policy. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date and also agree to pay for treatment rendered to the patient which is not considered to be a covered service by my insurer and/ or a third party insurer or other payer.

CERTIFICATION OF INFORMATION

I certify that the information I have provided Maximum Performance Physical Therapy & Fitness for payment including, but not limited to, related accidental illnesses or other insurers is accurate and truthful.

CONSENT FOR TREATMENT

I understand that I may have a condition requiring physical examination and/or medical treatment. I hereby voluntarily consent to such examination and treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment provided by Maximum Performance Physical Therapy & Fitness. I also acknowledge that consent for examination and treatment does not constitute a medical diagnosis.

Print Name	Signature of Patient or Responsible Party	Date

CANCELLATION/NO SHOW POLICY

Your scheduled appointment is a time set aside for your therapist to work with you individually. We design our schedule to allow at least 45 minutes with each and every patient and it is imperative that you attend your appointment and be on time. Your success depends on your attendence. If you are unable to keep your appointment, we ask that you call to cancel at least 24 hours in advance.

Failure to contact us in a timely manner will result in a $25 fee payable at your next visit.

Frequent cancellations or no shows will result in your discharge from our services.

Print Name	Signature of Patient or Responsible Party	Date

NOTICY OF PRIVACY PRACTICES

A copy of the *Notice of Privacy Practices of Maximum Performance Physical Therapy and Fitness* and *Patient Rights and Responsibilities* are available in the reception area for my information. I acknowledge that I have had the opportunity to read this document and ask for clarification.

Print Name	Signature of Patient or Responsible Party	Date

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FINANCIAL POLICY

We are committed to providing you with the best possible treatment. In order to achieve this goal, we need your understanding of our financial policies. If you have any questions regarding these policies, please contact our billing manager at 785-776-0670.

- It is your responsibility to know and understand your insurance plan limitations, maximum benefits, deductibles, co-payments, and co-insurance amounts.
- We strongly encourage you to call your insurance company and verify benefits.
- You are responsible for payment of all amounts not covered by your insurance.
- For patients who have not met their policy deductible, your estimated visit payment amount will be $50 each visit until your deductible is met.
- If you have a fixed co-payment amount verified by our office or listed on your insurance card, that amount will be collected at each visit.
- If any past due balance is not paid at the time of visit, the patient may be required to re-schedule the appointment.
- If you are unable to accommodate the above requirements, payment arrangements can be made by contacting the billing manager at 785-776-0670.
- Any credit balance on your account will be refunded as deemed appropriate by the billing manager.

I understand and agree that I am responsible for verifying my own insurance benefits. I agree to pay in full all charges shown on my billing statement upon receipt of the statement, unless other payment arrangements are made. It is agreed that payment will not be delayed or withheld because of any insurance claims pending or litigation. All proceeds of insurance are assigned to this office where applicable. A copy of this assignment is as valid as the original. In the event legal action should become necessary to collect unpaid balances due for any services rendered, I agree to pay reasonable attorney fees or such costs as the court determines proper.

Print Name	Signature of Patient or Responsible Party	Date

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MEDICAL HISTORY FORM - COMPLETE ALL SECTIONS IN FULL

First Name (Full Legal Name)	Middle Name	Last Name

Sex M ☐ F ☐	Age	Date of Birth	Height	Weight	Today's Date

DO YOU HAVE A PACEMAKER? YES ☐ NO ☐	METAL IMPLANTS? YES ☐ NO ☐	ARE YOU PREGNANT? YES ☐ NO ☐

Occupation	Currently Employed and Working? YES ☐ NO ☐

Currently Employed but NOT Working? YES ☐ NO ☐ Unemployed? YES ☐ NO ☐ Retired? YES ☐ NO ☐

Physical Activities at Work	Heavy ☐ Moderate ☐ Light ☐ Sedentary ☐
Physical Activities at Home	I exercise _____ times per week, **OR** I do not exercise regularly ☐

General Health	Good ☐ Average ☐ Fair ☐ Poor ☐	Stress Level	Low ☐ Medium ☐ High ☐
Do you use tobacco? YES ☐ NO ☐	How Much: _____ Packs/Day	Do you use alcohol?	How Much: _____ Drinks/Day
Date of Last Physical Exam		Hobbies	

ARE YOU CURRENTLY SEEING ANY OF THE FOLLOWING:

Physician/MD ☐	Orthopedic Surgeon ☐	Neurologist ☐	Dentist ☐
Chiropractor ☐	Physical Therapist ☐	Podiatrist ☐	Other (Specify) ☐

For what conditions are you seeing the above providers:

Please check any tests or procedures that have been done for your CURRENT condition

XRAY ☐ MRI ☐ CT SCAN ☐ NERVE CONDUCTION TEST ☐ BONE SCAN ☐ ULTRASOUND ☐ LAB WORK ☐

Results:

PAIN AND SYMPTOMS

Is your pain Occasional ☐ Continuous ☐

What makes your pain worse:

What makes your pain better:

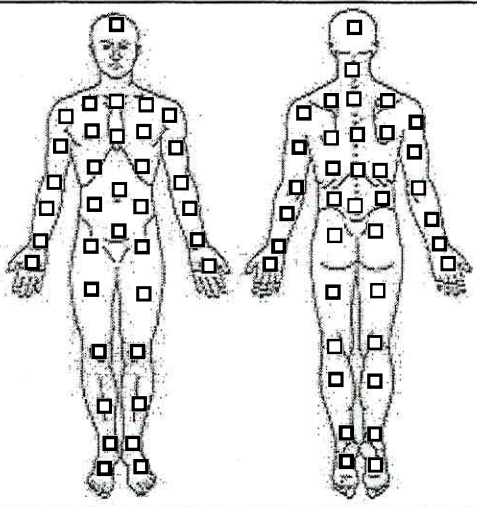
What is your pain at NOW: Select

What is your pain at WORST: Select

What is your pain at BEST: Select

How would you describe your pain:

Please mark areas of your pain



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MEDICAL HISTORY FORM CONTINUED - COMPLETE ALL SECTIONS IN FULL

In the past 6 months, have you had..... (please check all that apply)

Difficulty with bowel/bladder control ☐	Fever/Chills ☐	Numbness ☐
Night Pain/Sweating ☐	Weakness ☐	Chest Pains ☐
Unexplained weight gain/loss ☐	Leg Swelling ☐	Falls ☐
Vision/Hearing Problems ☐	Dizziness/Fainting ☐	Body Discomfort ☐
Numbness in the genital/anal area ☐	Shortness of Breath ☐	Other ☐

Have you ever been diagnosed as having any of the following..... (please check all that apply)

Emphysema/Bronchitis ☐	Asthma ☐	Kidney Disease ☐	High Blood Pressure ☐
Thyroid Problems ☐	Diabetes ☐	Hepatitis/HIV ☐	Low Blood Pressure ☐
Tuberculosis ☐	Depression ☐	Epilepsy/Seizures ☐	Rheumatoid Arthritis ☐
Anemia ☐	Stroke ☐	Heart Problems ☐	Chemical Dependancy ☐
Multiple Sclerosis ☐	Allergies ☐	Cancer ☐	Alcoholism ☐
Fibromyalgia ☐	Migraines ☐	Osteoporosis ☐	Parkinson's Disease ☐
Irritable Bowel Syndrome ☐	Other Arthritic Conditions ☐	Peripheral Neuropathy ☐	

Does any injury or condition significantly impact your function in these areas?

Work ☐ Food/Meals ☐ Emotional Stability ☐ Mobility ☐ Safety ☐
Transportation ☐ Finances ☐ Personal Care ☐ Social Activity ☐ Depression ☐

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your condition:

DATE	SURGERY/HOSPITALIZATION	REASON

What medications including prescriptions, herbal remedies and over the counter, or supplements in any form (pills, injections, skin patches) are you currently taking?

ALLERGIES: Latex ☐ Lotions ☐ Other:

Signature of Patient or Responsible Party

Signature of Therapist