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

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 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 #

PATIENT'S DOCTOR - Please your primary care physician below

Primary Care Physician's Name	Office Phone #

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 ☐	Unmployed Y ☐ N ☐
				Retired Y ☐ N ☐	

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 #

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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 online at https://maximumperform.com/notice-of-privacy/. 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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PHYSICAL THERAPY & FITNESS

Past Medical History

A complete medical history is necessary for a thorough evaluation and it will assist your therapist in developing an effective treatment plan. Please complete the following to the best of your ability. Please also fill out Symptom Detail Form for more detailed information regarding condition that brings you to therapy.

Full Legal Name _____ Today's Date _____

Height _____ Weight _____ Date of Last Physical Exam _____

Have you ever been diagnosed as having any of the following?

Heart Disease	Y	N	Asthma	Y	N	Rheumatoid Arthritis	Y	N
High Blood Pressure	Y	N	Allergies	Y	N	Osteoarthritis	Y	N
Stroke / CVA / TIA	Y	N	Depression	Y	N	Osteoporosis / Osteopenia	Y	N
Blood Clotting Disorder	Y	N	Kidney Disease	Y	N	Parkinson's Disease	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Multiple Sclerosis	Y	N
Cancer	Y	N	Epilepsy / Seizures	Y	N	Anemia	Y	N
Thyroid Problems	Y	N	HIV / AIDS	Y	N	COPD	Y	N
Are you currently pregnant?	Y	N						

Please list any additional diagnoses here: _____

Please list any surgeries you have undergone or conditions for which you have been hospitalized in the past 10 years:

Please mark any tests or procedures you have had done for your current condition:

☐ X-ray ☐ MRI ☐ CT Scan ☐ Nerve Conduction Test ☐ Bone Scan ☐ Ultrasound ☐ Lab Work

Please list any medications (and dosages) including prescriptions, over the counter, herbal remedies, or supplements you are currently taking:

In general, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No _____ packs / day Do you use alcohol? ☐ Yes ☐ No _____ drinks / week

Current Exercise Level: ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ 5+x/week Preferred Type of Exercise: _____

Problems with Exercise? ☐ Yes ☐ No If yes, please describe: _____

What do you hope to accomplish with therapy? _____

_____

Signature of Patient / Responsible Party _____

Signature of Evaluating Therapist _____

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Symptom Detail

Full Legal Name _____

Diagnosis (if you know or have been told) _____

_____

Body Part Affected (please circle area of primary concern):

Neck Mid Back Low Back Shoulder Elbow Wrist / Hand

Hip Knee Ankle Other _____

Which Side? ☐ Right ☐ Left ☐ Both

Problem(s) (please check all that apply)

☐ Pain

☐ Numbness

☐ Stiffness

☐ Swelling

☐ Weakness / Instability

☐ Other _____

Please circle the appropriate description of your pain:

Sharp Dull Achy

Shooting Burning Throbbing

Constant Intermittent

Worse in AM Worse in PM

How severe is your pain? (0 = None & 10 = Severe)

At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At its worst?	0	1	2	3	4	5	6	7	8	9	10
At its best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐ Yes ☐ No

Does the pain awaken you from sleep? ☐ Yes ☐ No

Have you ever been seen for this issue by any other provider (ie: physician, chiropractor, physical therapist)? ☐ Yes ☐ No

During this calendar year have you received any of the following treatments? (related or unrelated to today's visit)

☐ None

☐ Physical Therapy If so, how many visits? _____

Services rendered at _____

☐ Chiropractic If so, how many visits? _____

Services rendered at _____

☐ Home Health If so, how many visits? _____

Were you discharged from home health services? _____

Have you received any injections? ☐ Yes ☐ No

Have you had surgery? ☐ Yes ☐ No

Date of surgery? _____

Type of surgery? _____

This is a result of… (please mark all that apply)

☐ Injury Date of injury _____

☐ No injury / insidious onset Date it began _____

☐ Sports Injury Which sport? _____

☐ Motor Vehicle Accident Date of accident _____

☐ Work / Job Related

Please briefly describe how this began: _____

_____

_____

For Provider Use:

Resting HR: _____ bpm

Resting Blood Pressure: _____ mmHg

Height: _____ inches

Weight: _____ pounds

BMI: _____

Notes: _____

_____

_____