PATIENT REGISTRATION

PATIENT INFORMATION: (Please use full legal name)

First Name: ____________________ M.I. _____ Last Name: ____________________

Date of Birth: ____________________ Sex: _________ Social Security #: ____________________

Address: ____

City: ____________________ State: ____________________ Zip: ____________

Phone: ____________________ Email Address: ____________________

Employer: ____

Emergency Contact Name: ____________________ Emergency Contact Phone: ____________________

GUARANTOR INFORMATION: (If different from patient)

Relationship to Patient: ____

First Name: ____________________ M.I. _____ Last Name: ____________________

Date of Birth: ____________________ Sex: _________ Social Security #: ____________________

Address: ____

City: ____________________ State: ____________________ Zip: ____________

Phone: ____________________ Email Address: ____________________

PRIMARY INSURANCE INFORMATION: (Copy of card is required)

Insurance Company Name: ____

Insured's Relationship to Patient: ____

Complete the following if the Insured is NOT the Patient or Guarantor:

First Name: ____________________ M.I. _____ Last Name: ____________________

Date of Birth: ____________________ Sex: _________ Social Security #: ____________________

SECONDARY INSURANCE INFORMATION: (Copy of card is required)

Insurance Company Name: ____

Insured's Relationship to Patient: ____

Complete the following if the Insured is NOT the Patient or Guarantor:

First Name: ____________________ M.I. _____ Last Name: ____________________

Date of Birth: ____________________ Sex: _________ Social Security #: ____________________

SYMPTOM DETAIL

Full Legal Name: ____ Date: __________________________

DOB: ______________ Age: _______ Height: __________ Weight: _________ Date of Last Physical Exam: ______________

Diagnosis (if you know)____

Body Part Affected	Neck	Mid-Back	Low-Back	Shoulder	Elbow	Wrist/Hand	Hip	Knee	Ankle	Other:
Which Side	Right	Left	Both							
Problem(s)	Pain	Numbness	Stiffness	Swelling	Weakness	Instability	Other:			
Type of Pain	Sharp	Dull	Achy	Shooting	Burning	Throbbing	Constant	Intermittent	Worse in PM	Worse in AM
Aggravated by?										

Please list any tests or treatments done for your current condition (Physical Therapy, Chiropractic, Home Health, etc):

This is a result of:

☐ **Injury**	Date of Injury:	☐ **No Injury/Insidious Onset**	Date it began:
☐ **Sports Injury**	What Sport?	☐ **Car Accident**	Date of Accident:
☐ **Work Related**			

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

At its worst?	0	1	2	3	4	5	6	7	8	9	10
Currently?	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
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

PAST MEDICAL HISTORY

Have you ever been diagnosed with 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**	Other? Please List:					

Please list any surgeries and/or hospitalizations in the last 10 years:

Please list all medications and dosages. Please include, prescription, OTC, herbal remedies and supplements.

In general, how do you rate your overall health?	**Excellent**	**Good**	**Average**	**Fair**	**Poor**
Current Exercise Level	**None**	**1-2x Week**	**3-4x Week**	**5+x Week**	
How much sleep do you get on average?	**7-8 hours**	**Less than 7**	**More than 9**		
Is your stress level managed?	**Yes**	**No**	Do you drink plenty of water?	**Yes**	**No**
Do you smoke?	**Yes**	**No**	Do you use alcohol?	**Yes**	**No**

Signature of Patient/Guarantor: ____

MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS

FINANCIAL POLICY & PAYMENT AUTHORIZATION

- It is your responsibility to understand your insurance plan limitations, benefits, deductibles, co-pays and co-insurance amounts.
- You are responsible for payment of all amounts not covered by your insurance.
- If you have not met your deductible, your visit payment will be ***$50 per visit*** until that deductible has been met.
- If you have a set co-pay amount verified by our office and/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 your next appointment, you may be required to reschedule until payment is made.
- If you are unable to comply with our policy, payment arrangements can be made by calling our billing office at 785-776-0670.
- Any credit balance on your account at the end of treatment will be refunded as deemed appropriate.
- I authorize that the payment of my insurance benefits be made directly to Maximum Performance Physical Therapy for all services rendered. If I am paid directly, I will promptly pay Maximum Performance Physical Therapy all monies paid to me.
- 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 process 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.
- I certify that the information I have provided Maximum Performance Physical Therapy for payment including, but not limited to, related accident illnesses or other insurers is accurate and truthful.

★ _____________ *(guarantor initials)*

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. I further acknowledge that no guarantees have been made to me as to the results of treatment provided by Maximum Performance Physical Therapy. I also acknowledge that consent for examination and treatment does not constitute a medical diagnosis.

★ _____________ *(guarantor initials)*

CANCELLATION / NO SHOW POLICY

- We design our schedule to allow 45 minutes with each patient and it is imperative that you attend your appointment and be on time. 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 No Show Fee***. Frequent cancellations or no shows will result in your discharge from our services.

★ _____________ *(guarantor initials)*

NOTICE OF PRIVACY PRACTICES

- A copy of the Notice of Privacy Practices of Maximum Performance Physical Therapy and Patient Rights and Responsibilities are available online at www.maximumperform.com/notice-of-privacy. I acknowledge that I have had the opportunity to read this document and ask for clarification.

★ _____________ *(guarantor initials)*

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