MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS

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 #: _____

426A Mc Call Rd
Manhattan KS 66502
Ph: 785-776-0670
Fax: 785-776-0096

physicaltherapy@maximumperform.com
www.maximumperform.com

4201B Anderson Ave Ste. 1A
Manhattan KS 66503
Ph: 785-539-5555
Fax: 785-539-4551

MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS

FINANCIAL POLICY & PAYMENT AUTHORIZATION

- It is your responsibility to understand and verify your insurance plan limitations, benefits, deductibles, co-pays and co-insurance amounts. I acknowledge that my insurance eligibility has been provided to me, and I understand that is not a guarantee of payment.
- 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 a minimum of ***$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 you are unable to comply with our policy, payment arrangements can be made by calling our billing office at 785-776-0670.
- 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.
- Payment is due at time of service, unless previous payment arrangements have been made. It is agreed that payment will not be delayed or withheld because of any insurance claims pending or litigation. 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.
- Should you need to make payment arrangements, fill out a financial hardship form or have additional questions, please contact our billing manager at 785-776-0670.

☆ _____ *(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/legal guardian initials)*

CANCELLATION / NO SHOW POLICY

- We design our schedule to allow at least 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 48 hours in advance. Failure to contact us in a timely manner will result in a ***$50 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)*

X _____ _____ _____

Signature of Guarantor | Printed Name of Guarantor | Date

426A Mc Call Rd
Manhattan KS 66502
Ph: 785-776-0670
Fax: 785-776-0096

physicaltherapy@maximumperform.com
www.maximumperform.com

4201B Anderson Ave Ste. 1A
Manhattan KS 66503
Ph: 785-539-5555
Fax: 785-539-4551

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: _____

426A Mc Call Rd
Manhattan KS 66502
Ph: 785-776-0670
Fax: 785-776-0096

MAXIMUM PERFORMANCE
PHYSICAL THERAPY & FITNESS

4201B Anderson Ave Ste. 1A
Manhattan KS 66503
Ph: 785-539-5555
Fax: 785-539-4551