BACKtoGOLF PERFORMANCE & FITNESS

NAME_____ DATE OF BIRTH_____

PHONE #_____ CELL#_____ SOCIAL SECURITY #_____
(REQUIRED FOR WORK COMP)

MAILING ADDRESS _____ _____ _____ _____
Street or PO Box City State Zip

REFERRING MD _____ OCCUPATION_____ POSITION_____

Please describe your current complaint or limitation: _____

When did the condition begin? _____

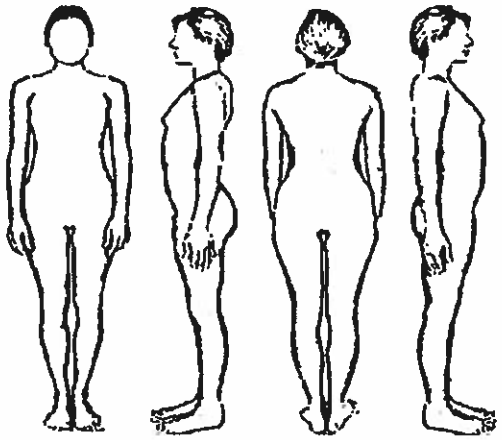
What is your goal for physical therapy? _____

Please describe the nature of your pain & indicate on the picture the location of your symptoms (*select all that apply*):

[ ] Sharp Pain [ ]Dull Pain [ ]Throbbing [ ]Shooting

[ ] Burning [ ]Tingling [ ]Numbness [ ] Tender

[ ]Constant [ ]Frequent [ ] Occasional [ ] Intermittent



Intensity of pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Intensity of pain with movement: 0 1 2 3 4 5 6 7 8 9 10

What causes pain to increase? _____

Date of Surgery (if applicable) _____

Activity Level (Circle One): LOW/SEDENTARY MEDIUM HIGH ATHLETE/SPORTS _____

Please check all boxes that apply:

PAST	PRESENT		PAST	PRESENT	
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Angina
[ ]	[ ]	Heart Attack	[ ]	[ ]	Stroke
[ ]	[ ]	Asthma	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Tumor	[ ]	[ ]	Cancer (Location:_____)
[ ]	[ ]	Systemic Lupus	[ ]	[ ]	Hepatitis
[ ]	[ ]	Epilepsy	[ ]	[ ]	Diabetes
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Pregnancy
[ ]	[ ]	Drug/Alcohol Dependence	[ ]	[ ]	Tobacco/Smoking
[ ]	[ ]	Other _____			

Current Medications: _____

Hospitalization/Surgical Procedures: _____

X_____ X_____ ____/____/____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**

BACKtoGOLF PERFORMANCE & FITNESS

CANCELLATION POLICY AND CONSENT TO TREAT

We at BACKtoGOLF Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointment is a necessary part of the treatment process. If there is not notice of cancellation **24 hours** before the scheduled appointment, a **$40 cancellation charge** will be billed directly to the patient for each cancellation. If you do not show up for a scheduled appointment, this same $40 charge will be assessed.

- If a patient "No-shows" for an appointment, any further appointments will require approval from the Office Manager.
- If a patient "No-shows" for a second time, no further appointments will be scheduled.
- If a patient cancels 2 appointments without 24 hours' notice, any further appointments will require approval from the Office Manager

By signing below, you acknowledged that you have read, understand and agree to abide by our cancellation policy as described.

I grant permission for the staff of BACKtoGOLF Physical Therapy to perform the procedures as prescribed by my physician including a physical therapy evaluation. During the evaluation, the nature of the procedure that will be performed as well as the potential risk of care will be explained to me.

If I become ill, while undergoing treatment. I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicate that I understand and give consent to be treated as Explained above.**

X_____ X_____ ____/____/____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**

*****OPTIONAL*** CREDIT CARD ON FILE FORM**

We have implemented a policy which enables you to maintain your credit card information securely on file with BACKtoGOLF Physical Therapy. In providing us with your credit card information, you are giving BACKtoGOLF permission to automatically charge your credit card on file for your co-pay/due balance **at time of service.** By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Name on Card: _____

Card Number: _____

Expiration Date: _____ **CCV #** _____ **Zip Code:** _____

Receipts?: YES / NO Email OR Text (Please provide email or phone #) _____

BILLING ADDRESS (If different than one on file – **IF SAME** LEAVE BLANK):

_____ _____ _____ _____

STREET CITY STATE ZIP

By signing below, I authorize BACKtoGOLF to charge co-pays and outstanding balances on my account to the above Credit Card.

X_____ _____

Authorizing Cardholders Signature Date

BACKtoGOLF PERFORMANCE & FITNESS

ASSIGNMENT OF BENEFITS

I hereby authorize the payment of medical benefits directly to **BACKtoGOLF PERFORMANCE AND FITNESS, INC**. I further authorize the release of health care information provided by the physical therapist to my insurance company or their agents for the purposes of administering claims for benefits. **I agree that I am financially responsible for all balances not paid by my insurance company.**

Benefit information obtained by BACKtoGOLF as a **courtesy** is not a guarantee of benefits or payments. **The patient is encouraged to contact their insurance company to obtain benefit information themselves.**

Our billing department will be kept in house at this time. This process can take up to 60 days to reconcile with your insurance company. Please be aware that you are incurring expenses during your treatment and you are responsible for those fees. **We ask than any portion that is your responsibility be paid in full within 60 days of your last appointment with us.** Other arrangements can be made with the owner or office manager if necessary.

PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE TO COPY TO KEEP ON FILE.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

BACKtoGOLF PERFORMANCE & FITNESS

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of you *Notice of Privacy Practices*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices.*

PLEASE ASK OUR FRONT DESK IF YOU WOULD LIKE TO RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I have reviewed the ASSIGNMENT OF BENEFITS disclosure as well as the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT above and am signing below to verify that all of my questions have been answered and that I understand all policies as stated above.

X_____ X_____ ____/____/____

Patient Signature **Guardian Signature (if patient is <18 years old)** **Date**