PERFORMANCE PHYSICAL THERAPY, LLC

☐ Chantilly clinic Tel (703) 263-2020 ☐ Gunston clinic Tel (703) 339-3767

PATIENT INFORMATION *(please print clearly)*

Are you a: ☐ New Patient ☐ Returning Patient ☐ Current Patient – Information has changed during treatment

Name: _____ Social Security #: _____

Last *First* *MI*

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ ☑ Primary Contact Preference ☐

Referring Doctor: _____

Home: _____ ☐

Have you had prior physical therapy this year?

Yes **No**

Work: _____ ☐ If Yes, explain:

Email: ☐

EMERGENCY CONTACT

Contact: _____ Relationship: _____

Phone #: Alternate Phone #:

HEALTH INSURANCE

Primary Insurance: _____

Subscriber: Relationship to Subscriber: DOB:

Secondary Insurance: _____

Subscriber: Relationship to Subscriber: DOB:

Tertiary Insurance: _____

Subscriber: Relationship to Subscriber: DOB:

MOTOR VEHICLE ACCIDENT *(if applicable)*

Date of Injury: What state did the accident occur in?

WORKER'S COMPENSATION *(if applicable)*

Worker's Comp Carrier: _____ Date of Injury: _____

Claim #: _____ Contact / Ph#: _____

Claim Address: _____

Employer:

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CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Performance Physical Therapy, LLC (D.B.A. Chantilly PT and Gunston PT) provide treatment and care as prescribed by my physician and/or recommended by my therapist. I understand physical therapy is not guaranteed to resolve my injury and/or injuries.

I certify that the information I have reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance carrier to determine benefits to which I may be entitled.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Performance Physical Therapy, LLC to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to Performance Physical Therapy, LLC.

Either my insurance carrier or I may revoke this authorization at any time in writing. I permit a copy of this authorization to be used in place of the original.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

You are responsible for payment of your deductible and co-payment / co-insurance as determined by your contract with your insurance carrier. All co-payments must be paid at the time of service. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

SELF PAY RATES: $150 Initial Evaluation and $80 Follow Up Appointments --- All self-pay payments must be paid at time of service.

DELINQUENT ACCOUNTS: Should your account become delinquent, you will be responsible for all collection costs which is 33% of the principal amounts.

RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $30.00 for any check returned by my financial institution regardless of reason.

APPOINTMENTS: There is a $50 fee charged for all NO SHOW / NO CALL visits as well as SAME DAY CANCELLATIONS.

AUTHORIZATION TO ACCESS MEDICAL RECORDS

I,_____, hereby authorize the following individual(s) access to my entire medical record contained by Performance Physical Therapy, LLC. I understand that I may revoke this authorization at any time by written notice.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I certify that I have read the above policies (i.e., Consent to Treatment and Authorization to Release Information, Patient Authorization for Direct Payment, Statement of Financial Responsibility, and Authorization To Access Medical Records) and herby give consent to each.

I understand that I may request a copy of this agreement at any time.

Signature: _____ Date: _____

Printed Name: _____