Patient Information

Full Name: ____
First *Middle* *Last*

Street Address: ____

Mailing Address: ____

City: ______________________ State: __________ Zip: ________

Date of Birth: __________ Social Security #: ____________________

Email: ________________ Cell: __________ Cell Provider: ________

Emergency Contact

Name: ______________ Relationship: __________ Phone: ____________

Insurance Information

_____ work related _____ auto accident _____ neither _____ other

Insurance Company ____________________ Policy/ID# ______________

Policy Holder: ____________________ Policy Holder's DOB: ______________

Relationship to patient: ______________

If work related, has your employer filed a worker's comp claim? __________

Contact/Case Manager: ____________________ *Phone:* ______________

Claim #: ____________________ *Date of Incident:* ______________

Employment Information

Employer/School: ____________________ Phone: ______________

Address: ____

City: ____________________ State: __________ Zip: __________

Occupation: ____________________ Supervisor's Name: ______________

MAXX PHYSICAL THERAPY

Medical History Evaluation

Name: ______________________________________ Date: __________

Referring Physician: ___________________________ Onset Date: __________

For this injury: Date of first doctor visit? __________ Last day worked? __________

Current work status: __________________ Is an attorney involved? YES NO

Have you had any other types of services for this injury/episode: YES NO

If so, what? *(i.e., x-rays, MRI, EMG,)* ________________________ Date: _________

Did you have surgery for this injury? YES NO

If yes, type of Surgery: ______________________________ Date: _________

Other Surgeries: ____

Do you now have or have you ever had any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, or Emphysema	___	___	Weakness	___	___
Shortness of Breath/Chest Pain	___	___	If so, where? __________________		
Coronary Heart Disease or Angina	___	___	Numbness / tingling	___	___
Do you have a pacemaker	___	___	Dizziness / faintness	___	___
High Blood Pressure	___	___	Hernia	___	___
Heart Attach / Surgery	___	___	Varicose Veins	___	___
Stroke / TIA	___	___	Allergies	___	___
Blood Clot / Emboli	___	___	Joint Replacement	___	___
Epilepsy / Seizures	___	___	Neck Injury/Surgery	___	___
Thyroid Trouble / Goiter	___	___	Shoulder Injury/Surgery	___	___
Anemia	___	___	Elbow Injury/Surgery	___	___
Infectious Disease	___	___	Back Injury/Surgery	___	___
Diabetes	___	___	Knee Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Leg/Foot Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Any Pins or Metal Implants	___	___
Osteoporosis	___	___	Are You Pregnant?	___	___
Gout	___	___	Sleeping Problems	___	___
Emotional/Psychological Problems	___	___	Bowel or Bladder Problems	___	___
How much do you smoke? _______________			Severe/Frequent Headaches	___	___
How much alcohol do you consume? ________			Vision or Hearing Difficulties	___	___

List any other information that would assist us in your care: ____________________

MAXX
PHYSICAL THERAPY

Medication List

Medicine	Dosage	Frequency

Patient Name: ______________________________

Consent for Evaluation and Treatment:

I hereby give permission for treatment and evaluation as well as therapy that was ordered by my physician.

Authorization to pay for Services:

I hereby authorize payment directly to my insurance and otherwise payable to the undersigned, but not to exceed therapy's regular charge for this service upon completion of a physical therapy session.

Agreement of Insurance Coverage:

I understand that if MAXX Physical Therapy does not accept my insurance I will be responsible for payments made directly to MAXX Physical Therapy in the form of out of network coverage or co-pay expenses. If my insurance denies payment to MAXX Physical Therapy, I understand that I will be responsible for payments or charges not covered by my insurance.

HIPPA Agreement/ Authorization to release Information:

By signing this form, I agree to authorize MAXX Physical Therapy to disclose confidential health information to include(name, address, SS#, employer, date of birth, relative's names, phone/fax e-mail address, Medical record #, Account #) any necessary information related to my financial records or medical records anyone involved in my care or by those with the appropriate need to do so, such as insurance, physician or other healthcare professionals.

Patient/Guarantor:________________________________ Date: __________

Parent/Guardian *(if under 18)*: ________________________ Date: __________

Staff/Title: _______________________________________ Date: __________

Patient Name: ______________________________

Appointment reminders: I would prefer appointment reminders sent via:

☐ Email ☐ Text

Please be punctual. We start and end appointments on a set schedule. It is important that you arrive as scheduled to receive your full treatment time.

Please give us 24-hour notice for appointment changes. A minimum 24-hour notice for changes in appointment time is required. Changes requested with less than 24 hours notice will be charged a ***$40.00 cancellation fee***. This fee will be due at your next visit. It is your responsibility to pay a cancellation fee, and it will not be billed to insurance or other payers.

Please come when scheduled. If you do not show up for a scheduled appointment, a ***$40.00 no-show fee*** will be due at your next visit. This fee is your responsibility, and it will not be billed to insurance or other payers.

25% Cancellation/No Show Policy: We reserve the right to cancel all future appointments if you miss more than 20% of your scheduled appointments. *(i.e., more than 1 cancellation or no show in 5 consecutive appointments)*

Workman's Compensation: We are required to send documentation of missed appointments to your worker's compensation case manager.

Self-Discharge: Please do not stop therapy without first talking to your therapist.

I have read and understand the policies listed above.

Patient/Guarantor:________________________________ Date: _________

Parent/Guardian *(if under 18)*: ________________________ Date: _________