



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: _____

Medical History Evaluation

Name: _____ Date: _____

Referring Physician: _____ Date problem started: _____

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 Attack / 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: _____

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: _____

Acknowledgement of Receipt of Notice of Privacy Policy

As part of my health care, MAXX Physical Therapy, LLC (DBA: MAXX Physical Therapy) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among MAXX Physical Therapy's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for MAXX Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that MAXX Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand MAXX Physical Therapy for Workman's Compensation Cases, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that MAXX Physical Therapy is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

- ☐ I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):
- ☐ I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

I acknowledge that I have received a copy of the Notice of Privacy Practices of MAXX Physical Therapy and agree to the liability limitations explained therein.

Signature of patient or legal representative

Printed name of patient

Date