MDuggan@ProFormanceTherapyandWellness.com
(F) 256-513-9952
127 Genesis Drive Huntsville, AL 35811
(P) 256-203-3804

PATIENT CONTACT INFORMATION

Patient Name _____ Today's Date _____
Address_____ City_____ State____ Zip _____
DOB_____ Age _____ Gender_____ Marital Status_____
Cell Phone _____ Home Phone _____
SSN _____Email_____
Employer_____ Occupation_____

Parent/Guardian/Spouse (circle one if applicable)
Name_____
Address_____City_____State_____
Cell Phone _____
Occupation_____

Emergency Information/ Nearest Relative if different than above
Name_____ Relationship_____
Address_____ City_____ State___ Zip _____
Cell Phone_____ Home Phone_____ Work Phone_____

Primary Insurance
Insurance Company Name_____
Policy Holder's Name_____
Policy Holder's DOB_____
ID Number _____ Group Number_____

Secondary Insurance
Insurance Company Name_____
Policy Holder's Name_____
Policy Holder's DOB_____
ID Number _____ Group Number_____

Insurance Policy Holder's Name (if someone other than the patient)
Name_____
Address_____City_____State_____
Cell Phone _____
Occupation_____

How did you hear about ProFormance?
_____

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CONSENT FOR COMMUNICATION

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. ProFormance Therapy and Wellness LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. ProFormance Therapy and Wellness LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail

E-mail address you consent to communicate through: _____

Phone number you consent to communicate through: _____

Patient Signature:

_____ Date_____

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Authorized Representative/Guardian Signature:

_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices located in the clinic office and/or on ProFormance Therapy and Wellness LLC's website.

_____ _____

Patient's or Guardian's Signature Date

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PATIENT QUESTIONNAIRE

Name of referring physician _____
Address _____
Phone _____ Fax_____
Date of next physician's visit: ___/___/___

Height _____ Weight _____ Gender _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Does anyone come to your home to provide health care needs (nursing, social work, physical/occupational/respiratory needs)? ☐ Yes ☐ No
Do you live alone? ☐ Yes ☐ No If no, who lives with you _____

Are you presently working? ☐ Yes ☐ No Occupation:_____
Work Activity (Check all that apply):
☐Sitting ☐Standing ☐Walking ☐Light Labor ☐Heavy Labor ☐Lifting <20 lbs. ☐Lifting >20#
Do you feel like your work station is ergonomic? ☐ Yes ☐ No

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe
_____

Sleep: ☐ Restless ☐ Restful Hours of sleep per night _____
Stress Level: ☐ High ☐ Moderate ☐ Low

Do you wear: ☐ Heel Lifts ☐ Orthotics ☐ Dental Night Guard ☐ CPAP ☐ None

PAST MEDICAL HISTORY

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Stroke/CVA	☐	☐
High Cholesterol	☐	☐	Hernia	☐	☐
Chest / Angina	☐	☐	Allergy to Heat	☐	☐
High Blood Pressure	☐	☐	Allergy/Cold Intolerance	☐	☐
Heart Disease	☐	☐	Latex Allergy	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker or Defibrillator	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Falls	☐	☐
Recent Fracture	☐	☐	Hypoglycemia	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐

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Osteoporosis	☐	☐	Current Infection	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma/Breathing Difficulty	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Sexual Dysfunction	☐	☐
Smoking	☐	☐	Are you pregnant?	☐	☐
Hernia	☐	☐	Other	☐	☐

If yes on any of the above, please briefly explain and give approximate date:

List any imaging you have had and when it was performed (X-ray, MRI, CT scan, etc.)

Have you had any surgeries? ☐ Yes ☐ No

If yes, please list what body part and when:

Were any of these surgeries related to the injury you are seeking therapy for? ☐ Yes ☐ No
If yes, which surgery? _____

Please list any medication you are taking and what condition they are for.

Is there any other information regarding your past medical history we should know about?

_____

_____

Date of injury / onset: ___/___/___
Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No

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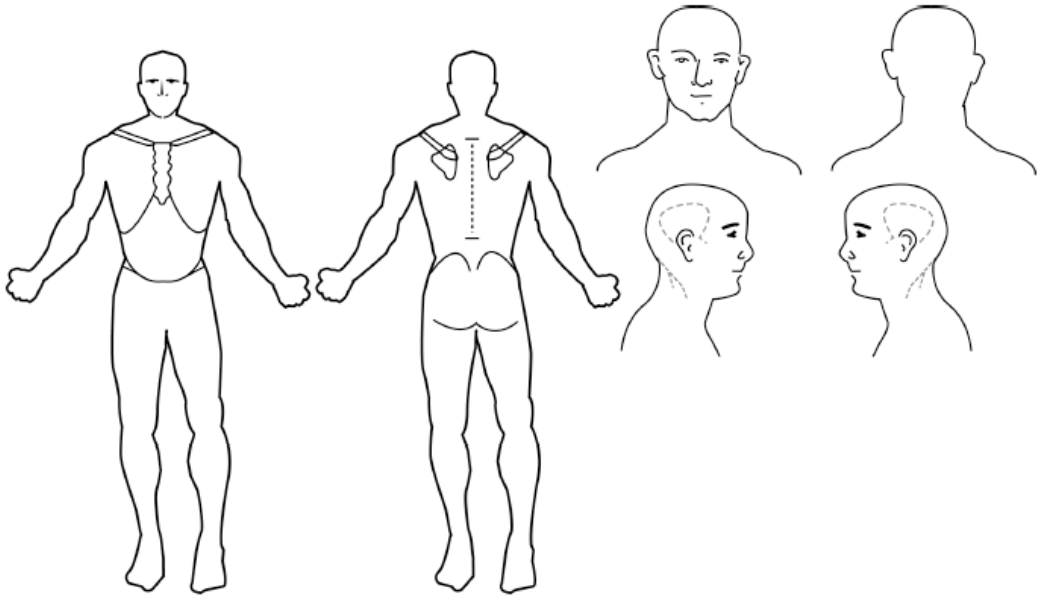
If yes, did you have treatment for these symptoms? ☐ Yes ☐ No
What made them better? _____
What made them worse? _____
What are you most limited in doing as a result of your symptoms?
_____

Check which apply to your symptoms:

☐ work related injury	☐ recurrence of previous injury	
☐ motor vehicle accident	☐ injury related to lifting	☐ injury related to falling
☐ cause unknown	☐ athletic / recreational injury	☐ other: _____

Please indicate below where your symptoms are located.



If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

Is the pain/paresthesia:
☐ Deep ☐ Achy ☐ Sharp ☐ Shooting ☐ Numb ☐ Tingling

_____ ____/____/____
Patient's Signature Date

_____ ____/____/____
Signature of Guardian if patient is a minor Date

_____ ____/____/____
Therapist Signature Date

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Payment Agreement

Thank you for choosing ProFormance Therapy and Wellness, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected in full at time of service unless we are in-network with or agree to accept assignment from your health plan or other responsible payor or you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **TriCare Policy.** We are out-of-network with TriCare Standard and Prime Plans. However, we will agree to accept assignment for TriCare claims, which means we will await payment from TriCare and bill you for your co-share of the bill and any remaining charges after TriCare processes your bill. Limiting charges will apply to medically necessary services that are covered benefits. If TriCare does not cover a service you receive, you will be responsible for the entire charge. We will only bill TriCare for services we consider medically necessary. However, you should be aware that TriCare determines whether a claim is payable in accordance with their determination of what is medically necessary. We do not know how TriCare determines medical necessity and therefore cannot guarantee your claims for our services will be paid. Therefore, you will be responsible for paying for all services TriCare does not cover.
- **Medicare Policy.** We are not enrolled as a participating provider with Medicare Part B. You understand and agree that you have been fully informed in advance about what interventions and/or services, if any, are not covered by Medicare and therefore not subject to Medicare's fee schedule for participating providers and have agreed to pay our charges for those services. This includes services which are not paid by Medicare because the service is not covered or Medically necessary. We may ask you to sign an Advanced Beneficiary Notice if we don't believe Medicare will cover a service you have chosen to receive.
- **Wellness & Fitness Services.** Commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
    - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
    - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are

exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

Assignment of Benefits and Authorized Representative Appointment

Assignment of Benefits. I hereby assign and convey directly to Provider all health plan benefits, TriCare and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I also hereby assign and convey any and all rights under ERISA and any other applicable state and federal laws to pursue payment for Provider's services until Provider's claims are paid in full, including but not limited to legally required notices and procedural reviews concerning my benefits and filing a civil action in federal court. I understand that I will no longer be entitled to said rights. I also understand that I may revoke this assignment at any time by sending written notice to the Provider and my health plan. l hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

X _____ Date: _____
Signature of Patient and/or Guardian

X_____ Date: _____
Signature of Provider Representative
A photocopy of this agreement is to be considered valid, the same as if it was the original.