

FOUNDATION *performance*

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Have you previously seen, or are you currently seeing, any other health care provider for this problem?

Yes No

If **yes**, check all that apply:

- Physician
- Physical Therapist
- Osteopath
- Chiropractor

- Podiatrist
- Dentist
- Other, please list: _____

Please check those treatments listed below that have been tried in the past:

- Physical Therapy
- Tens Unit
- None
- Chiropractic
- Injections
- Other (please describe): _____
- Acupuncture
- Medications

MEDICAL HISTORY – Please check YES or NO					
Allergies	Yes ___ No ___	Depression	Yes ___ No ___	Multiple Sclerosis	Yes ___ No ___
Anemia	Yes ___ No ___	Diabetes	Yes ___ No ___	Osteoporosis	Yes ___ No ___
Anxiety	Yes ___ No ___	Dizzy Spells	Yes ___ No ___	Parkinson's	Yes ___ No ___
Arthritis	Yes ___ No ___	Emphysema/ Bronchitis	Yes ___ No ___	Rheumatoid Arthritis	Yes ___ No ___
Asthma	Yes ___ No ___	Fractures	Yes ___ No ___	Seizures	Yes ___ No ___
Cancer	Yes ___ No ___	Gallbladder Problems	Yes ___ No ___	Speech Problems	Yes ___ No ___
Hepatitis	Yes ___ No ___	Cardiac Conditions	Yes ___ No ___	Strokes	Yes ___ No ___
Tuberculosis	Yes ___ No ___	High blood pressure	Yes ___ No ___	Thyroid Disease	Yes ___ No ___
Metal Implants	Yes ___ No ___	Incontinence	Yes ___ No ___	Cardiac Pacemaker	Yes ___ No ___
Circulation Problems	Yes ___ No ___	Kidney Problems	Yes ___ No ___	Vision Problems	Yes ___ No ___
Currently Pregnant	Yes ___ No ___	Chemical Dependency	Yes ___ No ___		

Describe any other conditions or explain above conditions: _____

Surgical History Check here if a surgical history was provided

Surgery type: _____ When (MM/YYYY): ____/____/____

Surgery type: _____ When (MM/YYYY): ____/____/____

Current Medications Check here if a medication list was provided

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

Job Description/Social Activities (physical tasks, amount of sitting, lifting, desk work, etc.): _____

What are your **goals** for your course of physical therapy? _____

Patient Signature: _____ **Date:** _____

Therapist Name (Print and Sign): _____

ATTENTION:

If you are attending today's physical therapy evaluation and have not obtained an order, prescription, or referral from a physician, please read the following:

The Rhode Island Practice Act for Physical Therapy states:

Whenever a patient seeks or receives treatment from a physical therapist without referral from a doctor of medicine, osteopathy, dentistry, podiatry, chiropractic, physician assistant, or certified registered nurse practitioner, the physical therapist shall:

(1) Disclose to the patient, in writing, the scope and limitations of the practice of physical therapy and obtain their consent in writing; and

(2) Refer the patient to a doctor of medicine, osteopathy, dentistry, podiatry, or chiropractic within ninety (90) days after the date treatment commenced; provided, that a physical therapist is not required to make this referral after treatment is concluded;

Your signature below attests that you have read and understand this notice, and that Foundation Performance Inc. has made documents available to you which satisfy the above-listed requirements.

Patient Name (Printed)	Patient Signature	Date
Parent or Guardian (Printed) (if patient is under 18)	Parent or Guardian Signature	Date
Staff Witness (Printed)	Staff Witness Signature	Date

CONFIRMATION OF REFERRAL (THIS SECTION TO BE COMPLETED AT A LATER DATE)

Your signature below attests that Foundation Performance, Inc. referred you to the following physician:

Patient Name (Printed)	Patient Signature	Date
Parent or Guardian (Printed) (if patient is under 18)	Parent or Guardian Signature	Date
Staff Witness (Printed)	Staff Witness Signature	Date

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RELEASE OF LIABILITY

I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in a physical therapy or exercise/fitness program. I also acknowledge that it has been recommended that I have a yearly or more frequent physical exam and consultation with my physician concerning health and physical activity so I might have his/her recommendations. I acknowledge that I have had a physical exam and have my physician's approval for physical activity, or that I have decided to participate in physical activity and use exercise equipment without approval of my physician and do hereby assume all responsibility for my participation in this program. I hereby authorize Foundation Performance Inc. to conduct physical therapy and or exercise services.

Patient Name (Printed)

Patient Signature

Date

Parent or Guardian (Printed) (if patient is under 18)

Parent or Guardian Signature

Date

Staff Witness (Printed)

Staff Witness Signature

Date

PRIVACY AND INFORMATION

I understand that Foundation Performance Inc. complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the **treatment, billing, and collection** pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance or to any medical provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name (Printed)

Patient Signature

Date

Parent or Guardian (Printed) (if patient is under 18)

Parent or Guardian Signature

Date

Staff Witness (Printed)

Staff Witness Signature

Date

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HEALTH INSURANCE INFORMATION

PRIMARY Health Insurance Co Name _____
ID Number _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Relationship to patient _____

SECONDARY Health Insurance Co Name _____
ID Number _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Relationship to patient _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Foundation Performance Inc. for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____ Patient Name (Printed)	_____ Patient Signature	_____ Date
_____ Parent or Guardian (Printed) (if patient is under 18)	_____ Parent or Guardian Signature	_____ Date
_____ Staff Witness (Printed)	_____ Staff Witness Signature	_____ Date

If your injury is **MOTOR-VEHICLE ACCIDENT** related:

Date of Accident _____ Location of Accident (State) _____
Claim # _____
Insurance Carrier Liable for Medical Expenses _____
Name of Insurance Representative / Adjuster / Claims Manager _____
Insurance Phone Number _____

If your injury is **EMPLOYMENT / WORKER'S COMPENSATION** related:

Date of Loss _____ Location of Loss (State) _____
Employer _____
Employer Phone _____
Employer Address _____
Claim # _____
Insurance Carrier Liable for Medical Expenses _____
Name of Insurance Representative / Adjuster / Claims Manager _____
Insurance Phone Number _____

APPOINTMENT POLICY

PLEASE READ !

We would like to ensure that all clients receive the utmost in quality care and service, and that each client will have scheduled appointments according to their needs and our availability. Consequently a cancellation and no show policy have been implemented. Missed and cancelled visits are controllable variables that can help keep the cost of services down. Your cooperation is greatly appreciated.

If you must cancel an appointment we request that you provide at least 24-hour notice.

- Any cancelled visit with more than 24 hours notice will not be subjected to a fee.
- Any cancelled visit with less than 24 hours notice will be subjected to a \$25 cancellation fee.
- Any missed visit without prior notice will be subjected to the full visit amount.
- Clients who repeatedly violate the appointment policy may forfeit their time slots.

I have read and agreed to the appointment policy explained above.

signature

date