Patient Name: _____ Date:_____

ASCENT
PHYSICAL THERAPY & PERFORMANCE

Patient Demographics:

Name:

_____
First Middle Initial Last

Home Address:

_____
Street Apt, Unit, etc City State Zip

Home Phone: _____ **Mobile Phone:** _____

May we leave you a message pertaining to:

Appointments? ◯ YES ◯ NO Medical Info? ◯ YES ◯ NO Billing? ◯ YES ◯ NO

Date of Birth: _____ **Gender:** _____ **Social Security Number**: _____

Email:_____

Employer: _____**Occupation:** _____

Emergency Contact:

_____

_____

_____
First Name Last Name Emergency Phone Relationship to Patient

Insurance Information

Primary Insurance

_____ _____ _____
Name of Insurance ID Number Group Number

_____ _____
Name of Policy Holder Date of Birth

Secondary Insurance

_____ _____ _____
Name of Insurance ID Number Group Number

_____ _____
Name of Policy Holder Date of Birth

Patient Name: _____ Date:_____

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Permission to Release Medical Information

Federal law requires your permission before we discuss your healthcare with any friends or family members. Please list any persons (besides your other physicians) with whom we may discuss your care:

_____

_____

_____

_____

Name Relationship to Patient

Guarantor if Patient is a Minor

Name:

_____

First Last Date of Birth Relationship to patient

Address:

_____

Street Apt, Unit, Etc City State Zip

Physician Information

Primary or Referring Doctor: _____

Other Physicians you see?

_____

_____

_____

Name Reason

Have you had Home Health in the last 30 days? ☐ Yes ☐ No

Third-Party Information

Is this current episode of physical therapy the result of an injury caused by an auto accident, third party, or employment? ◯ YES ◯ NO

Print Name: _____ Signature: _____

** If this is related to a motor-vehicle accident or third-party other than workers comp, please notify our office immediately**

Patient Name: _____ Date:_____

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If this is a work-related injury, please fill out the following:

Employer's Name: _____

Employer's phone: _____

Employer's Address:

_____

Street Apt, Unit, etc City State Zip

_____ _____

Workers Comp Carrier **Workers' Comp Carrier Phone**

Workers' Comp Carrier Address

_____

Street Apt, Unit, etc City State Zip

Claim/Case number: _____

Case Manager's Name: _____ **Phone:** _____

Adjuster's Name: _____ **Phone**: _____

Patient Name: _____ Date:_____

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PHYSICAL THERAPY & PERFORMANCE

Health History:

Age:_____ **Height**: _____ **Weight**: _____

Current Condition in which you are seeking treatment:

_____

_____

Have you had any of the following? Check all that apply (if none, check none of the above)

☐ Anemia
☐ Anxiety
☐ Asthma
☐ Bowel/Bladder Problems
☐ Cancer
☐ Cardiac Conditions
☐ Cardiac Pacemaker
☐ Chemical Dependency
☐ Currently Pregnant
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Emphysema/Bronchitis
☐ Fractures
☐ Gall Bladder Problems
☐ Gastro-intestinal disease
☐ Heart Attack
☐ Hepatitis (Type) _____
☐ High Blood pressure
☐ Incontinence
☐ Kidney Disease
☐ Metal implants
☐ Multiple sclerosis
☐ Osteoporosis
☐ Osteoarthritis
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Prosthesis/Implant
☐ Rheumatoid Arthritis
☐ Seizures
☐ Stroke/TIA
☐ Thyroid Disease
☐ Tuberculosis
☐ Vision Problems
☐ Spinal Cord Stimulator
☐ Lung Disease
☐ Blood Clots
☐ Autoimmune Disease (Type) _____
☐ HIV
☐ Recent Fever/chills/sweats
☐ Ringing in Ears
☐ Hearing Loss
☐ Nausea/Vomiting
☐ Headaches
☐ Unexplained weight change
☐ Pan that wakes you at night
☐ Chest Pain/Angina
☐ Shortness of Breath
☐ Do you exercise regularly
☐ Do you drink alcohol
☐ Do you use tobacco
☐ None of the Above
☐ Other

If other, please explain:

_____

_____

_____

Patient Name: _____ Date:_____

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List current Medications:

_____
_____
_____
_____
_____
_____

Name	Dosage	Frequency	Prescribing Physician

Surgical History:

_____
_____
_____
_____
_____
_____

Recent Imaging:

_____
_____
_____
_____

Where is your current pain located? _____

When did it start: _____

Mechanism of injury (How did it happen): _____

Rate your current pain 0-10 (0= no pain, 10= worst pain imaginable): _____

Is your pain? ◯ Constant ◯ Intermittent (comes and goes)

Do you have? ◯ Numbness ◯ Burning ◯ Tingling

Patient Name: _____ Date:_____

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PHYSICAL THERAPY & PERFORMANCE

Authorizations:

Treatment of Self or Minor

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above-named patient, performed by the staff at Ascent Physical Therapy and Performance and/or as directed by my referring services.

Photo/Video Release

I grant to Ascent Physical Therapy and Performance and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation, therefore I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

Notice of Privacy

I acknowledge that I have received the practice/clinic's Notice of Privacy, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. The Notice of Privacy is located on the Ascent website at ascentphysicaltherapyokc.com. I understand that I may contact Ascent if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy.

Insurance Benefits

I authorize my insurance company to pay benefits directly to Ascent Physical Therapy and Performance and/or its clinicians. I understand that I am financially responsible for services rendered by the clinician and his/her staff as determined by my insurance company. I also understand that all copays are due at the time of my visit. I agree that all the above information is true and correct to the best of my knowledge. In accordance with HIPAA regulations, I acknowledge that I have been given a copy of Ascent Physical Therapy and Performance's Notice of Health Information Practices.

By signing below, you are agreeing to all above stated Authorizations:

_____Printed Name _____ Date

_____Signature

Patient Name: _____ Date:_____

ASCENT
PHYSICAL THERAPY & PERFORMANCE

Financial Policy:

We contract with several healthcare insurance programs. If your insurance plan is one of our contracted plans, we will bill your insurance on your behalf. Your payment method that is kept on file with be charged for any remaining balance not covered by insurance. This will occur if you have a deductible or co-insurance. It is your responsibility to pay any deductible amount, co-insurance, or any remaining balance left unpaid by your insurance provider. If we are filing claims with your insurance company, we are contractually obligated to collect your copay. We will collect it at the time of service. Our office does not bill co-pays. Co-pays are the patient's responsibility and are due at the time of service. Physical Therapy is classified differently based on your insurance provider. Please check with your insurance company whether or not physical therapy is considered a specialty service. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We cannot waive co-pays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

Payment arrangements are required at the time of your visit. I authorize Ascent Physical Therapy and Performance LLC to charge my payment method an amount equal to the balance of charges within 90 days of the date of service, but not to exceed $100 *per date of service*, and to store that card account information for future transactions. I understand that after insurance has processed a statement of any remaining balances over the authorized amount may be billed to me. I represent and warrant that I am the primary cardholder or authorized user of the card. This authorization is effective as of the date below and is reflected in Merchant's record and will remain in full force and effect until I notify Merchant that I wish to revoke this authorization. I understand that payments made prior to my cancellation of this authorization are subject to Merchant's general terms and conditions for refunds. I understand that Ascent Physical Therapy and Performance LLC will notify me by email, at the email address I have provided, of any changes to this authorization. I understand that it is my responsibility to update my information on file with the Merchant should my email address, contact, or card information change.

If you are a self-pay patient, you must pay in full at the time of service. Self-pay patients, who are new to the practice, will be required to pay $150 at the initial appointment. Your initial appointment includes evaluation and treatment. Established patient visits are $100 per visit. Discount may apply for pre-paying of visits.

By signing below, you are agreeing to all above stated Authorizations:

_____ Printed Name _____ Date

_____ Signature