PRIMO
Performance & Rehabilitation

2525 Wallingwood Dr. Bldg 7A Ste 702A
Austin, TX 78746
PT 512 228 1411
OT 512 774 0260
[info@primorehab.com]
[www.primorehab.com]
FAX 512 382 9639

Date:

First Name	Last Name	
Address		
City	State	Zip
Best Phone Number to Reach You		
E-mail*		Birthday

How did you hear about PRIMO Performance & Rehab? Check all that apply.

☐ Friend : ☐ Physician: ☐ Web ☐ Other

*** By providing us your e-mail address you agree to receive messages regarding treatment and scheduling from PRIMO Performance & Rehab. We will also be able to send you your financial statement via e-mail when needed.**

Emergency Contact	
Relationship to you	Phone
Physician	Phone
Presenting Problem(s)	Date of Injury

PRIMO Performance & Rehab Only Files with Blue Cross Blue Shield (BCBS)		
BCBS Member ID #	Group #	
BCBS Phone	Authorization Required? Yes No	
Deductible: $	Copayment: $	Benefit Level: %

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Medical History

Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Skin conditions	☐	☐	HIV/AIDS
☐	☐	Diabetes	☐	☐	Liver disorder or disease	☐	☐	Tuberculosis
☐	☐	Heart disease/condition	☐	☐	Kidney or bladder disorder	☐	☐	Arthritis
☐	☐	Chest pain	☐	☐	Thyroid disorder	☐	☐	Dizziness
☐	☐	High blood pressure	☐	☐	Intestinal disorder	☐	☐	Smoking
☐	☐	Stroke	☐	☐	Seizures	☐	☐	Obesity
☐	☐	High Cholesterol	☐	☐	Open sore/wounds			
☐	☐	Anemia or blood condition	☐	☐	Hepatitis			
☐	☐	Alcoholism	☐	☐	Eating disorder (Previous)			
☐	☐	Asthma	☐	☐	Eating disorder (Current)			
☐	☐	Other Pulmonary disorder	☐	☐	Reflux			

☐ ☐ Other medical Conditions:_____

Current or recent medications including supplements:

_____

_____

Surgeries/Hospitalizations & Date

_____

_____

Injuries/Fractures/Dislocations & Date

_____

_____

Current areas of discomfort/dysfunction

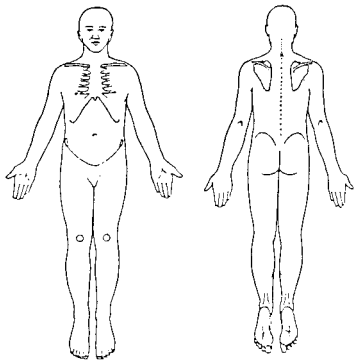
_____

_____

Scars or areas of previous trauma

_____

_____



Please mark Areas of Complaint

I have completed this questionnaire and have had any questions regarding its content answered fully.
Due to the hands on nature of the treatment and the treating therapist's safety, if information has been left out for confidentiality, please verbally communicate it to the therapist performing the evaluation.

Signature:_____

Signature of guardian and consent for treatment if under 18 years of age:_____

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Physical & Occupational Therapy Procedures, Polices, and Practices

PHYSICIAN PRESCRIPTIONS/REFERRALS – An OT or PT may do an initial evaluation without a prescription; any follow-up treatment must be prescribed by a physician as dictated by Texas State Law. If you do not have a physician, I can refer you to one.

THERAPY DRESS - Please dress in baggy shorts and a tee shirt. Women also wear a sports bra or something similar that you feel comfortable wearing without a shirt if you upper extremity or spine is being examined. Bring athletic shoes if possible, especially if your injury is related to athletic activities.

THERAPY ARRIVAL - When you arrive for your appointment please have a seat in the waiting area. We do not have a receptionist. We try to run on time, but at times we may run a few minutes late.

PAYMENT OPTIONS - Payment is due at time of your visit, by check, cash, or credit card. PRIMO only files Blue Cross Blue Shield health insurance.

INSURANCE BILLING – PRIMO only files with Blue Cross Blue Shield. However, the therapy you receive is generally covered by most insurance carriers and ppo's as "out of network services."
IN ADDITION,

PRIMO Performance & Rehab IS NOT A MEDICARE PROVIDER OR MEDICARE CERTIFIED FACILITY. CHARGES WILL NOT BE COVERED BY MEDICARE.

The invoice PRIMO will provide you will have all the information necessary for you to file for reimbursement. If your plan requires additional documentation, daily notes and/or evaluations, they will be provided to you by your therapist for you to submit. If requested, your therapist will assist you with your claims at an hourly rate equivalent to those billed for therapy.

CANCELLATION POLICY - Due to the low volume nature of our practice, we generally have a waiting list, which necessitates a **24 hour** cancellation notice prior to your scheduled appointment. This will allow us adequate time to fill your slot. Any appointment cancelled without at least a 24 hours notice will be billed at full price. Exceptions for sudden illness or emergencies will be respected.

If you have any questions, concerns, or comments, please call us at 512.228.1411 for PT or 512.774.0260 for OT or email at info@primorehab.com

BY SIGNING BELOW, I AGREE TO THE FOLLOWING PROCEDURES, POLICIES, AND PRACTICES.

*SIGNATURE:*_____ *DATE:*_____ _

Please check one of the below

☐ ***I authorize*** *PRIMO Performance & Rehab to provide medical and billing information to my insurance company, if requested, regarding my treatment and condition for reimbursement purposes.*

☐ ***I do not authorize*** *PRIMO Performance & Rehab to provide medical and billing information to my insurance company, if requested, regarding my treatment and condition for reimbursement purposes*

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Medically Informed Consent for Treatment

I voluntarily consent to physical or occupational therapy treatment and services deemed necessary by my physical therapist, occupational therapist, and/or physician. I am aware that the practice of physical therapy or occupational therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at PRIMO Performance & Rehab. It is the therapist's and facility's sincere intent to educate me on the processes of treatment and eventually discharge from our services. Therefore, if "hands-on" manual therapy techniques and/or exercise techniques that are being used to retrain, recruit, and restore normal musculoskeletal function are not understood or desired, it is my responsibility to obtain a clearer understanding of the therapist's objectives and outcomes, and how he/she is trying to achieve them or refuse this aspect of treatment. If I do not consent or feel uncomfortable physically or emotionally with any aspect of the treatment, it is also my responsibility to make this immediately clear to the therapist providing the treatment.

This consent shall be on-going for the treatment period.

I have read this form and fully understand and accept its terms and conditions:

Patient signature or person authorized to consent for patient. Date/Time

Medically Informed Consent for Dry Needling Treatment

I voluntarily consent to dry needling treatment as deemed helpful to treating my condition by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at PRIMO Performance & Rehab.

I understand Dry needling is a medical modality with certain risks. Positive reactions include relaxation, feeling energized, and tiredness. Negative reactions include pain where needle is inserted, mild bleeding where needle is inserted, bruising, syncope, nausea, sweating, mild bleeding, disorientation, localized or diffuse aching, localized itching and burning, tingling. If performed in the trunk or rib cage areas, rare risks include visceral injury, pneumothorax, bleeding, and infection. Therefore, if dry needling techniques that are being used to retrain, recruit, and restore normal musculoskeletal function are not understood or desired, it is my responsibility to obtain a clearer understanding of the therapist's objectives and outcomes, and how he/she is trying to achieve them or refuse this aspect of treatment.

If I do not consent or feel uncomfortable physically or emotionally with any aspect of the treatment, it is also my responsibility to make this immediately clear to the therapist providing the treatment.

Techniques performed will and do conform to standards set and instructed by the American Dry Needling Institute. If any adverse reactions occur, I will contact my physical therapist and seek immediate medical attention if necessary.

This consent shall be on-going for the treatment period.

I have read this form and fully understand and accept its terms and conditions.

Patient signature or person authorized to consent for patient. Date/Time