Human Performance Institute

1184 East 80 North, American Fork, UT 801-756-7777
J. Robert Sumsion, MSPT Sharla Natter, DPT, ATC

Appointment Date:

Time:

PATIENT INFORMATION CHART#

Patient name LAST: FIRST: MIDDLE:	**Date of Birth:** mm/dd/yy / /	**Marital status (circle one):** Single/ Mar / Div / Sep / Wid

Street address:	**City:**	**State:**	**ZIP:**	**Sex:** ❑ M ❑ F

Home phone #: ( )	**Cell phone #:** ( )	**Employer phone #:** ( )

Best time of day to reach you:	**How did you hear about us? CHECK ALL THAT APPLY** ❑ Doctor ❑Website ❑ Other:_____ ❑ Family or friend (their name):_____

Social Security #:	**Primary care physician:**	**Referring physician:**

INSURANCE INFORMATION

(Only fill out this section if you have not handed your card to the office staff to copy)

PRIMARY Insurance:	Policy holder's name: Date of birth:	Relationship to patient:

Policy ID#:	Group #:

Claims address:

SECONDARY Insurance:	Policy holder's name: Date of birth:	Relationship to patient:

Policy ID#:	Group #:

Claims address:

Is this a **work related injury**? If yes, list employer: Date of injury:	Worker's Compensation Carrier: Claims address:	Adjuster's name and phone #: Claim #:

Is this injury from an **auto accident**? Date of injury:	Auto Insurance Carrier: Claims address:	Adjuster's name and phone #: Claim #:

Please: SIGN BOTH MISSED APPT and HIPPA POLICIES!!!

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENTS:
It is our policy to require payment of all office charges at the time they are rendered, unless prior arrangements plans have been specifically made. All accounts over 90 days will be referred to a collection company. In the event any balance due hereunder is not paid as agreed, the undersigned jointly agrees to pay all costs charged by the collection company, and our company, which costs will not exceed 33% of the unpaid balance.

INSURANCE POLICY:
Insurance provides reimbursement for you on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

AUTHORIZATION FOR RELEASE OF INSURANCE AND MEDICAL RECORDS:
I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I hereby, authorize the Therapist to release any medical information including: diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I HAVE READ AND UNDERSTAND THESE POLICIES. I HAVE ALSO READ AND UNDERSTAND THE "NOTICE OF INFORMATION PRACTICES" AND WILL BE PROVIDED WITH A COPY IF REQUESTED.

SIGNED: _____DATE: _____
RELATIONSHIP TO PATIENT (if other than self): _____

***NOTICE: For the safety of everyone in our facility we require children who are not patients to remain in the waiting area if they must accompany you to your appointment.**

MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously. Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget. With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24 hours' notice. In such a case, please call our office and arrange for a make-up appointment. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without a 24 hours' notice or no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

J. Robert Sumsion and Sharla Natter
Human Performance Institute

I HAVE READ AND UNDERSTAND THIS POLICY: _____ DATE: _____

Please Print Name:_____