**LEGENDARY PERFORMANCE**
*Restore · Perform · Recover*

410 N. Palafox Street, Pensacola, FL 32501
P: 850-332-7681 F: 850-512-1188

# PATIENT INTAKE FORM

## 1 · PATIENT INFORMATION

| Full Legal Name | | Preferred Name | |
|---|---|---|---|
| Date of Birth | Social Security # | | |
| Street Address | City | State | Zip |
| Occupation | Employer | Emergency Contact & Phone | |

### Preferred Contact Method (check one)

□ Home Phone: _____

□ Cell Phone: _____ (Text: Yes / No)

□ Email*: _____

** Email used for appointment reminders and Home Exercise Programs*

## 2 · INSURANCE & BILLING

| Primary Insurance — Name | Policy # |
|---|---|
| Secondary Insurance — Name | Policy # |
| Tertiary Insurance — Name | Policy # |

### How Did You Hear About Us?

□ Doctor Referral: _____

□ Friend / Family Referral: _____

□ Social Media

□ Internet Search

□ Radio / TV Commercial

□ Walk-In

□ Current Patient

□ Other: _____

| Referring Doctor / Practice (if applicable) | Primary Care Provider/ Practice: |
|---|---|

## 3 · MEDICAL HISTORY

| Prior PT for This Condition? ☐ Yes ☐ No | Any PT This Year? ☐ Yes ☐ No | Surgery for This? ☐ Yes ☐ No | Date of Surgery |
|---|---|---|---|
| | | | |

| Hospitalized for This? ☐ Yes ☐ No | From Date | To Date | Home Health Care? ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

| Recent Falls? ☐ Yes ☐ No | Date of Last Fall | Other Surgical History |
|---|---|---|
| | | |

| Current Medications (or attach separate list — note date last revised by PCP) | |
|---|---|
| | |

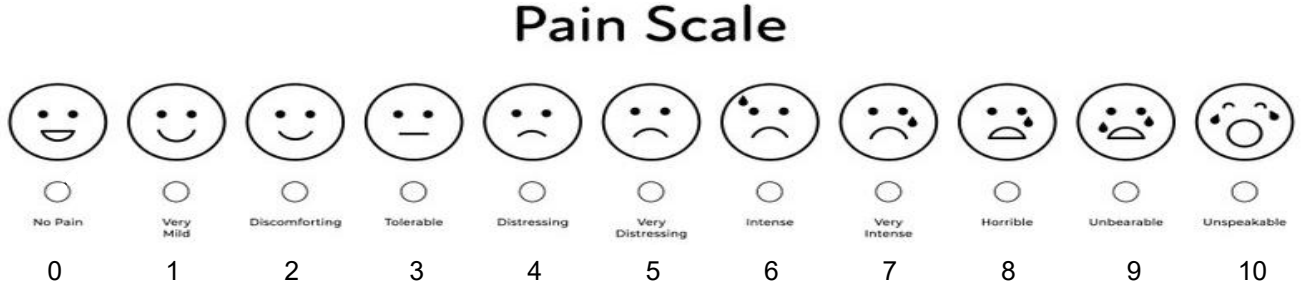
| **Nicotine? ☐ Yes ☐ No Type:_____** | **Pregnant? ☐ Yes ☐ No** | **Alcohol (drinks/week)** |
|---|---|---|
| | | |

### Current or Past Medical Conditions (check all that apply)

| | | |
|---|---|---|
| □ Asthma / Bronchitis / Emphysema | □ Arthritis / Swollen Joints | □ Shortness of Breath / Chest Pain |
| □ Varicose Veins | □ Osteoporosis / Osteopenia | □ Pacemaker |
| □ High Blood Pressure | □ Severe / Frequent Headaches | □ Cancer / Chemo / Radiation |
| □ Sleeping Difficulties | □ Thyroid Trouble / Goiter | □ Diabetes (Type: ____) |
| □ Heart Attack / Heart Surgery | □ Vision / Hearing Difficulties | □ Gout |
| □ Emotional / Psychological Issues | □ Anemia | □ Coronary Heart Disease |
| □ Stroke / TIA | □ Dizziness or Faintness | □ Bowel or Bladder Problems |
| □ Epilepsy / Seizures | □ Infectious Disease | □ Joint Replacement (Joint: ____) |

## 4 · CURRENT PAIN

| Current Pain (0–10) | Worst Pain (0–10) | Best Pain (0–10) |
|---|---|---|
| | | |



## 5 · REASON FOR VISIT & GOALS

| Primary Complaint / Reason for Visit | When Did This Begin? (approx.) |
|---|---|
| | |

| Diagnostic Testing Done (X-ray, MRI, CT — include type & date) | |
|---|---|
| | |

| Work-Related Injury? ☐ Yes ☐ No | Auto Accident? ☐ Yes ☐ No | Claim # (if yes) | Date of Injury |
|---|---|---|---|
| | | | |

### Primary Goals (check all that apply)

□ Reduce Pain / Manage a Condition
□ Recover from Injury or Surgery
□ Improve Mobility & Flexibility
□ Increase Strength & Function
□ Return to Work / Daily Activities
□ Return to Sport or Recreation
□ Improve Energy & Overall Health
□ Weight Management
□ Performance Enhancement
□ Fall Prevention / Balance
□ Recovery & Longevity
□ Other: _____

### Activity Level (check one)

□ Sedentary — desk job or minimal movement
□ Lightly Active — walks, light daily tasks
□ Moderately Active — exercise 1–3 days/week
□ Active — exercise 4+ days/week
□ Competitive Athlete / Active Training

| What activities or hobbies are most important for you to get back to or improve in? |
|---|
| |

| What does success look like when your care at Legendary Performance is complete? |
|---|
| |

### Services — Would You Like to Learn More About? (check all that apply)

□ Physical Therapy
□ Personal Training (1-on-1)
□ Small Group Training
□ Sports Performance Training
□ Massage / Manual Therapy
□ Nutrition Guidance
□ Body Composition Analysis
□ Recovery Services (Dry Needling, Cupping, Compression, etc.)

### Payment Policy

Payment is due at time of service. If insured, your estimated copay/deductible is due at each visit. We accept cash, check (with ID), credit/debit, and HSA/FSA cards. Accounts with balances unpaid after 90 days are subject to collection; all resulting costs are the patient's responsibility.

### Insurance Responsibility

You are responsible for knowing your coverage, using participating providers, and paying out-of-pocket costs at time of visit. All charges not paid by your insurer are your responsibility. Notify us immediately of any insurance changes during treatment.

### Cancellations & No-Shows

24-hour advance notice is required to cancel or reschedule. No-shows and late cancellations are subject to a fee up to $50.00 (not covered by insurance). Missed appointments are reported to your physician and insurer. Workers' Compensation patients: non-compliance may result in termination of treatment.

### Cash-Pay & Direct-Pay Services

Legendary Performance offers recovery and performance services outside of physical therapy — these are not billed to insurance and payment is required at time of service. Our team can provide a current fee schedule upon request.

**ACKNOWLEDGEMENT: I have read and understand the payment policy, insurance responsibilities, and cancellation policy above. I accept responsibility for any charges not covered by my insurance carrier.**

| _____ | _____ | _____ |
|---|---|---|
| *Signature (Patient or Parent/Guardian if Minor)* | *Relationship* | *Date* |

## 6 · AUTHORIZATIONS & CONSENTS

## Consent to Treat

I, _____, consent to receive treatment at Legendary Performance. I authorize the release of any medical information necessary to process my claim to healthcare providers, attorneys, insurers, or others I designate. I authorize payment to be made directly to Legendary Performance regardless of network participation.

| _____ | _____ | _____ |
|---|---|---|
| *Signature (Patient or Parent/Guardian if Minor)* | *Relationship* | *Date* |

## Notice of Privacy Practices (HIPAA)

I acknowledge receipt of the Notice of Privacy Practices. Protected health information (PHI) is used only for treatment, payment, and healthcare operations — never for marketing, employment, or life insurance purposes without my explicit authorization. I understand the practice may update this policy and will provide a revised copy upon request.

| _____ | _____ | _____ |
|---|---|---|
| *Signature (Patient or Parent/Guardian if Minor)* | *Relationship* | *Date* |

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# HIPAA PRIVACY POLICIES

It is the policy of ***Legendary Physical Therapy and Wellness*** that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have all the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting our practice and its provider and staff or purposes of treatment, payment, and healthcare operations (TPO), knowing that our practice and its providers and staff will--

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use, and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.

Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its providers and staff will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its providers and staff always respect the patient's individual dignity. Our practice and its providers and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its providers and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its providers and staff will --

- Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Revised 5/30/2024