

Visit History Waiver

Your insurance has a visit limit and/or requires authorization for physical therapy, which may be based upon physical therapy services rendered by another type of provider. Due to this limitation by your insurance we must be aware of your past therapy history. Please circle the answers below that apply to you and complete any necessary information.

Yes/No I have had physical, occupational or speech therapy under my current insurance.

Yes/No I have had or am currently receiving chiropractic services under my current insurance.

Yes/No I am currently receiving home health services under my current insurance.

Yes/No I am currently receiving hospice care under my current insurance.

If you answered yes to either statement above, please list the related condition(s) and the year(s) that you received treatment. If you are currently receiving treatment for a condition, indicate accordingly.

ACKNOWLEDGEMENT

I am aware that if I provide any false information on this form (including omission of information) that results in claim denial with Maximum Performance Physical Therapy, I will be financially responsible for those visits at the prevailing self pay rate.

Patient/Guardian Signature

Date