Peak Performance
PHYSICAL THERAPY INC.

WC

704 Mowry Ave Fremont, CA 94536 ▲ (510)790-3213 ▲ Fax (510)790-3337

Please Print Legibly

Patient Information

Full Legal Name:		
Social Security Number:		**Date of Birth:**
Age:	**Preferred Name:**	**Gender:**
Address:		
City, State, and Zip Code:		
Home Phone:		
Cell:		
Email:		
Next MD Visit:		

Employment Information

Name of Employer:	
Occupation/Position:	
Work Phone:	

Emergency Contact Information

Person to contact in case of emergency:	**Relationship:**
Emergency Contact Phone Number:	

Physician Information

Referring Physician:	**Phone:**
Primary Care Physician:	**Phone:**

General Questionnaire

Medical/Surgical History:

Check all that apply. Have you ever had:

Pacemaker	☐ ☐		
Broken Bones/Fractures	☐ ☐	Parkinson Disease	☐ ☐
Osteoporosis	☐ ☐	Seizures/ Epilepsy	☐ ☐
Blood Disorders	☐ ☐	Arthritis	☐ ☐
Low Blood Sugar/ Hypoglycemia	☐ ☐	Recent unexplained change in weight	☐ ☐
Depression	☐ ☐	Cancer	☐ ☐
Heart Problems	☐ ☐	Thyroid Problems	☐ ☐
High Blood Pressure	☐ ☐	Circulation/ vascular problems	☐ ☐
Lung Problems	☐ ☐	Infectious Disease	☐ ☐
Stroke	☐ ☐	Kidney problems	☐ ☐
Diabetes/ High Blood Sugar	☐ ☐	Ulcers/ Stomach problems	☐ ☐
Other:			

For Men Only: Have you been diagnosed with prostate disease?

Yes ☐ No ☐

For women only: Have you been diagnosed with:

1. Complicated pregnancies/ deliveries Yes ☐ No ☐
2. Pregnant, or think you might be pregnant Yes ☐ No ☐

Current Condition(s)/ Chief Complaint

Describe the problem(s) for which you seek physical therapy:

When did the problem(s) begin? (month/year)

What happened? _____

1. How are you taking care of the problem(s) now?

2. What makes the problem(s) better?

3. What makes the problem(s) worse?

4. What are your goals for physical therapy?

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Surgical History

Have you ever had surgery?

Yes ☐ No ☐

If yes, please describe, and include dates (Month/Year)

1

2

3

4

Medications

Do you take any medication? Yes ☐ No ☐

If yes, please list:

I hereby give lifetime authorization for payment of insurance benefitsto be made directly to Peak Performance Physical Therapy Inc. and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize Peak Performance Physical Therapy Inc. to release all information necessary to secure the payment of benefits. I further agree that a photocopy or a facsimile of this agreement is as valid as the original. I further authorize that my signature on this form constitues assignment of benefits to Peak Performance Physical Therapy Inc. I consent to have Peak Performance Physical Therapy Inc. and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand that this consent may be revoked by me at any time.
Patient/ Parent/ Guardian Signature: Date:

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Patient Privacy Notice

THIS ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION

HOW WE MAY USE AND DISCLOSE HEALTHCARE INFORMATION ABOUT YOU

- We may use health information about you:
  - To provide youwith health care treatment or services
  - So that the services we provide to you may be billed to our practice
  - For operations that are necessary to run our practice
  - To tell you about health related services
  - When necessary to prevent a serious threat to the health and safety of you, someone else, or the public
  - If you are a member of the armed forces or separated/dishcarged from military service, to disclose such information as requested by military command authorities or the Department of Veteran Affairs
  - To release such information to Worker's Compensation or similar programs (These programs provide benefit for work-related injuries or illnesses)
  - To disclose such information to a health oversight agency as authorized by law
  - If you are involved in a lawsuit or a dispute, to disclose information in response to a court or administrative order, etc.
  - To release such information to law enforcement when asked to do so

YOUR RIGHTS REGARDING HEALTHCARE INFORMATION ABOUT YOU

- You have the following rights:
  - To inspect and copy health information that may be used to make decisions about your care
  - To request amendments to your health information if you feel there are inaccuracies
  - To request a list that will account for any disclosure of your health information that we have made, except for used and disclosures for treatment, payment, and healthcare operations as previously described
  - To request a restriction or limitation on the health information we use or disclose about your for treatment, payment, or healthcare operations
  - To request that we communicate with you about health matters in a certain way or a certain location
  - To obtain a paper copy of the entire privacy policy notice at any time

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE AT ANY TIME. WE WILL POST A COPY OF THE CURRENT NOTICE IN OUR FACILITY. IF YOU WOULD LIKE A COMPLETE COPY OF THE PROTECTED HEALTH INFORMATION PRIVACY NOTICE, PLEASE ASK THE OFFICE MANAGER.

Patient/ Parent/ Guardian Signature: Date:

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ANNOUNCEMENT TO ALL PATIENTS RECEIVING WORKER'S COMPENSATION BENEFITS

(Please initial and sign where indicated)

_____ Our treatments are by schedule only. It is important for you to notify us **24 hours** in advance if you must cancel a schedule appointment. **We are required to report all missed appointments, whether no show or cancellation, to your insurance adjuster and/or your employer.** Canceling and/or no showing for your physical therapy appointments may affect worker's compensation benefits.

_____This form authorizes Peak Performance Physical Therapy to release to the following named: physician, insurance carrier, social services and/or attorney; any medical information including statements of your account, which are pertinent to this injury and/or illness which may be requested and is to comply with their terms of the Confidentiality Medical Information Act.

Our office has obtained and documented authorization for physical therapy from the insurance company handling your claim. This relieves you of the responsibility of paying for any "non-covered" services or balances. If you wish to purchase therapy equipment during your course of treatment, we ask that you pay at the time of purchase and submit your receipt to your insurance company for reimbursement.

Patient/ Parent/ Guardian Signature:	Date: