



**Important Notice:**

It is the patient's responsibility to know and understand their personal insurance plan coverage for Physical Therapy such as copay, deductible, and visitation limit for the year. **The information we receive is just a quote.** It is **NOT** our responsibility to notify you on what those benefits are.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Requesting for Medical Records:**

Should you ever request for a copy of your Medical Records this notice is just to notify you that our office charges \$15.00. Please allow 48 hours to prepare them, and we will contact you once their available for pickup.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Cancellation/No Show Policy**

**We require a minimum of 24 hour notice in the event of a cancellation**

**There is a \$25.00 charge for same day cancellation or without proper notice**

Please understand that this charge **will not be covered by your insurance** and will have to be **paid by you.**

**We may choose to exercise discretion for the first offense**

Everyone has unforeseen complications from time to time so we may choose to overlook a no-show or improper cancellation the first time, however a second time will result in a charge. If this becomes a trend, it will result in the system automatically removing all future appointments.

**WE RESERVE THE RIGHT TO CHANGE THIS AT ANY TIME**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Information			Employment Information	
Full Legal Name:			Name of Employer:	
Social Security Number:		Date of Birth:	Occupation/Position:	
Age:	Preferred Name:	Gender:	Work Phone:	
Address:			Emergency Contact Information	
City, State, and Zip Code:				
Home Phone:			Emergency Contact Phone Number:	
Cell:			Physician Information	
Email:				
Next MD Visit:			Primary Care Physician:	Phone:

**General Questionnaire**

**Medical/Surgical History:**

Check all that apply. Have you ever had:

yes no		yes no	
Pacemaker	( ) ( )	Parkinson Disease	( ) ( )
Broken Bones/Fractures	( ) ( )	Seizures/ Epilepsy	( ) ( )
Osteoporosis	( ) ( )	Arthritis	( ) ( )
Blood Disorders	( ) ( )	Recent unexplained change in weight	( ) ( )
Low Blood Sugar/ Hypoglycemia	( ) ( )	Cancer	( ) ( )
Depression	( ) ( )	Thyroid Problems	( ) ( )
Heart Problems	( ) ( )	Circulation/ vascular problems	( ) ( )
High Blood Pressure	( ) ( )	Infectious Disease	( ) ( )
Lung Problems	( ) ( )	Kidney problems	( ) ( )
Stroke	( ) ( )	Ulcers/ Stomach problems	( ) ( )
Diabetes/ High Blood Sugar	( ) ( )	Other:	

**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?

\_\_\_\_\_

**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 ( )



**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 benefits to 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 constitutes 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:



## MEDICARE GUIDELINES

Dear Patient,

This letter is to inform you of a change that has occurred in Medicare outpatient rehabilitation service coverage. Medicare has notified us that there is no longer a limit or “cap” on the number of Physical Therapy a patient can have within one calendar year (January-December). All visits are based on medical necessity.

### How this affects you:

- Medicare requires a referral from a physician in order for any patient to receive Physical Therapy services.
- The referral **MUST** be dated within 30 days of treatment and is the patients’ responsibility to obtain a referral and provide our office with a copy.
- We can only see you for the total number of visits prescribed by your physician. If you would like to continue treatment past the number of visits you were seen, we will need an updated referral in order to continue treatment.

Our goal is to provide you with the care and education you need to obtain your greatest functional outcome. Your therapist will work with you to develop a plan to best utilize your visits.

Please direct all questions regarding your Medicare limitations to the front office. For any billing questions, please contact our office at (510) 790-3213 and ask to speak to billing.

**I HAVE READ AND UNDERSTAND THE MEDICARE GUIDELINES. I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR MEDICARE CO-PAYMENTS, ANNUAL DEDUCTIBLE, AND ALL CHARGES NOT DETERMINED MEDICALLY NECESSARY BY MEDICARE.**

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**

- To provide you with health care treatment or services
- So that the services we provide to you may be billed to our practices
- 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 or a member of the armed forces or separated/discharged 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 health care information about you**

- 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 you for treatment, payment or health care 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 anytime

**We reserve the right to change this notice at any time.** We will post a copy of the current notice in our facility.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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- So that the services we provide to you may be billed to our practices
- 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 or a member of the armed forces or separated/discharged 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.
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