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:_____

PEAK PERFORMANCE PHYSICAL THERAPY

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:			**Emergency Contact:**	**Relationship:**
Home Phone:			**Emergency Contact Phone Number:**	
Cell:			Physician Information	
Email:			**Referring Physician:**	**Phone:**
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	[ ]	[ ]			
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?

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 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:

ANNOUNCEMENT TO ALL PATIENTS RECEIVING

WORKERS COMP 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 scheduled appointment. **We are <u>required</u> to report all missing appointments, whether no show or cancellation to your insurance adjuster and/or your employer.** Cancelling and/or noshowing for your Physical Therapy appointments may affect worker's compensation benefits.

_____This form authorizes Peak Performance Physical Therapy to release any medical information including statements of account which are pertinent to this injury and/or illness to the following parties: physician, insurance carrier, social services and or attorney. This information must 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, we ask that you pay at the time of purchase and submit your receipt to your insurance company for reimbursement.

Patient's Signature: _____ Date:_____

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:_____