Peak Performance
PHYSICAL THERAPY INC.

MC

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

Please Print Legibly

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:			**Person to contact in case of emergency:** / **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?

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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 you with 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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CANCELLATION / NO SHOW POLICY

●WE REQUIRE A MINIMUM OF 24 HOURS NOTICE IN THE EVENT OF A CANCELLATION

It is **your responsibility** when you call in to have an alternate time in mind so we can ensure you will receive the full prescribed number of treatments that week

●THERE IS A $25.00 CHARGE FOR CANCELLATION 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 unforseen 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.** After the second or third instance occurs, we will have to question your commitment to your treament program and all your future appointments may be taken off the schedule.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE AT ANY TIME

Patient/ Parent/ Guardian Signature: Date:

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Cancellation / No Show Policy - Patient Copy

IN ORDER TO CONTINUE TO PROVIDE YOU WITH THE HIGHEST LEVEL OF SERVICE POSSIBLE, AND FOR THE CONSIDERATION OF OTHER PATIENTS AND THERAPISTS, WE ASK THAT YOU COME TO YOUR APPOINTMENT AT THE SCHEDULED TIME.

IF YOU ARE LATE, YOU MAY BE ASKED TO RESCHEDULE FOR ANOTHER TIME AND/OR DATE.

IF YOU ARE 15+ MINUTES LATE FOR YOUR APPOINTMENT, YOUR VISIT WILL BE CANCELLED AND YOU MAY BE SUBJECT TO A NO SHOW FEE UNLESS OTHERWISE DIRECTED BY THE FRONT DESK.

AS A REMINDER, THE POLICY YOU SIGNED IS:

- **WE REQUIRE A MINIMUM OF 24 HOURS NOTICE IN THE EVENT OF A CANCELLATION**
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MEDICARE CHANGES

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 effective January 1, 2013 there is a $1,900 cap per benficiary (patient) per calendar year. Please understand that Medicare regulates these changes, which affect all therapy providers.

This $1,900 limit applies to physical therapy and speech language services with a separate $1,900 limit on occupational therapy services. Our recommendation is that you assume that you have a "bank account" of 16-18 visits that you can use per calendar year.

Please be aware that if service continues past the $1,900 cap amount, you, the patient, become responsible for payment. **This is why it is critical that you notify us if you have seen a physical, occupational, or speech therapist prior to your visit with us.**

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 feel free to direct all clinical questions to your therapist. For all billing questions, please call (650)319-8016

I HAVE READ AND UNDERSTAND THE MEDICARE CHANGES FOR 2013. I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR MEDICARE CO-PAYMENTS, ANNUAL DEDUCTIBLE, AND ALL CHARGES EXCEEDING THE $1,900 CAP LIMIT.

Patient/ Parent/ Guardian Signature:	Date: