PEAK PERFORMANCE Physical Therapy

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Residential Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Primary Phone: _____ Alternate Phone: _____ Email: _____

Sex: ☐ Male ☐ Female ☐ Other _____ Preferred Pronouns: ☐She/Her ☐He/Him ☐They/Them ☐Other _____

Date of Birth: _____ SSN: _____ - _____ - _____

Emergency Contact Name and Phone: _____

Guarantor – if patient is under 18 years old:

First Name: _____ Last Name: _____ Relation to patient: _____

SSN: _____ - _____ - _____ Phone: _____ Address: _____

How did you hear about us? _____

☐ Farm Bureau ☐ Playmakers ☐ HPI ☐ M43 ☐ Other Community Partner: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Return Appointment Date with Referring Physician: _____ / _____ / _____

EMPLOYMENT INFORMATION

Employer/School: _____ Occupation: _____

INSURANCE INFORMATION - *leave blank if same as patient*

Primary Insurance Company: _____ Policy #: _____ Group #: _____

Full Name of Policy Holder: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Policy Holder Birth Date: _____ Policy Holder Sex: ☐ Male ☐ Female

Phone: _____ Insured's Employer: _____

Secondary Insurance Company: _____ Policy #: _____ Group #: _____

Full Name of Policy Holder: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Policy Holder Birth Date: _____ Policy Holder Sex: ☐ Male ☐ Female

Phone: _____ Insured's Employer: _____

AUTO OR NON-WORK-RELATED ACCIDENT - *Claims must have prior authorization prior to services being rendered.*

Insurance Company _____ Claim # _____

Adjuster's Name _____ Phone/Fax # _____

If pursuing litigation:

Name of Law Firm _____ Name of Attorney _____

Address of Law Firm _____

City_____ State _____ Zip _____ Phone/Fax # _____

WORKER'S COMPENSATION - *WC claims must have prior authorization prior to services being rendered.*

Worker's Compensation Carrier _____Adjuster _____
Phone/Fax # _____
Case Manager _____ Phone/Fax #_____ Claim # _____
Do you have an attorney? Yes/ No Attorney's Name_____ Phone/Fax_____
Mailing Address _____

PEAK PERFORMANCE FINANCIAL POLICY - *please initial*

_____ As a courtesy to our patients, we will verify your insurance coverage and benefits (*verification is only a quote) as well as file claims for you. This is not a guarantee of payment and is subject to the information given to us. It is your responsibility to call & check the information given to us regarding your insurance.

_____ Any additional forms needing to be filled out by a provider will have a $30 fee for the first five pages and a $5 fee for each additional page

_____ We require 24-HOUR NOTICE for any cancellation. A fee of $25 or the full amount of your appointment will be charged to your account for failure to comply.

_____ Your Physical Therapist may utilize electrical stimulation in your treatment. In an effort to promote hygiene, all patients normally are provided with their own electrodes. The cost of these electrodes is $15.00. This will be billed to your insurance, but if your insurance does not pay, you will be billed $15.00.

TREATMENT AUTHORIZATION AND PRIVACY NOTICE

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent / legal guardian for all minors.

Receipt of Notice of Privacy Practices Form: I, hereby acknowledge receipt of Peak Performance Physical Therapy's Notice of Privacy Practices. Peak Performance Physical Therapy will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Peak Performance Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Peak Performance Physical Therapy to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Peak Physical Performance Therapy.

Signed: _____ Date: _____
If you are not the patient, please specify your relationship to the patient _____
Minors under 18 must have guardian/parent sign

_____

Parent/Guardian Signature / Printed Name Date

MEDIA RELEASE

Media Release: Signing below irrevocably grants to Peak Performance Physical Therapy, PLC, its employees, agents, representatives, and consultants, permission to use your name, voice, likeness and image in videos and digital still images, audio tapes, recordings, reproductions, websites, (i.e. documents, DVDs, movies and any or all photographs). You are also agreeing that your likeness and image may be altered, modified, or otherwise changed in the uses referenced above. You are also releasing Peak Performance Physical Therapy PLC, its employees, agents, representatives, and consultants from any and all claims including but not limited to, damages, libel, slander, invasion of the right of privacy, or any other claim based on the uses allowed above. I realize no promises have been made to me in exchange of my signature on this release and no compensation will be received by the undersigned. I also understand my participation in any taping or photography is purely voluntary and I may or may not have notice that taping or photography is happening. I have read this release agreement and fully understand the meaning of it. I am of legal age and have every right to sign this form**.**

Signed: _____ Date: _____
If you are not the patient, please specify your relationship to the patient _____
Minors under 18 must have guardian/parent sign

HIPAA DISCLOSURE AUTHORIZATION

If you would like any of your protected health information disclosed to a family member, spouse, etc. please fill out this form, indicating the name of the individual(s). If you do not want your protected health information disclosed to anyone, please check the box below and sign your name at the bottom.

☐ I would not like my protected health information disclosed to any individual with the exemption of my insurance company and referring doctor.

☐ I hereby authorize Peak Performance Physical therapy to use or disclose my protected health information related to Physical Therapy to _____.

I understand that I may inspect or copy the protected health information described by this authorization.

- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____

Date Signature of Individual or Representative

_____

Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on_____

*If no date or event is stated, the expiration date will be six years from the date of this authorization

OUTPATIENT SCREENING FORM

Patient Name_____ Age_____ Height_____ Weight_____ BMI _____

What date (roughly) did your present symptoms start? _____

My symptoms are currently: **Getting better** **Getting worse** **Staying the same**

Treatment received so far for this problem (please circle):

Chiropractic **Acupuncture** **Injections** **Physical/Occupational Therapy** **Other**: _____

Have you received physical/occupational therapy within the last calendar year*?* **YES** **NO**

Special tests performed for this problem and results (please circle):

X-ray **Bone Scan** **CT scan** **MRI** **Other**: _____

Occupation, including activities that comprise your workday (please circle):

Sitting **Standing** **Walking** **Lifting** **Other**: _____

Are you on a work restriction from your doctor: **None** **Light duty** **Full Duty** **Not Working**

LEISURE ACTIVITIES (include exercise routines): _____

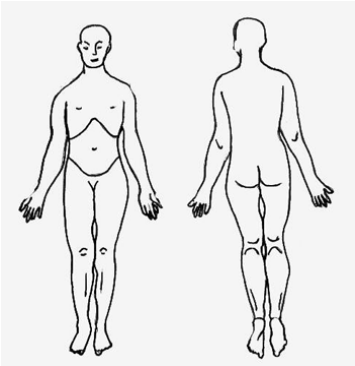
ALLERGIES: List any medication(s) you are allergic to: _____

What type of home environment do you live in now (private home, assisted living, etc?_____

What is your goal for therapy? _____

Please mark the areas where you feel symptoms on the chart using these symbols:

xxx Shooting/sharp pain 000 dull aching pain //// numbness ### tingling



My symptoms currently: **COME AND GO** **ARE CONSTANT** **CONSTANT, BUT CHANGE WITH ACTIVITY**

Please rate your current level of pain on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours on the following scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms *better*: _____

What makes your symptoms *worse*: _____

Indicate which conditions you have or ever had:

Arthritis	Yes No	Diabetes	Yes No	Numbness/Tingling	Yes No
Osteoporosis	Yes No	Anemia	Yes No	Thyroid Problems	Yes No
High Blood Pressure	Yes No	Swelling in Ankles	Yes No	Headaches	Yes No
Heart Disease/Heart Attack	Yes No	Deep Vein Thrombosis (DVT)	Yes No	Head Injury/Concussion	Yes No
Pacemaker	Yes No	Seizures/Epilepsy	Yes No	Hernia	Yes No
Stroke	Yes No	Fatigue/Weakness	Yes No	Kidney/Bladder Problems	Yes No
Vascular Disease	Yes No	Cancer/Tumor	Yes No	Previous Fractures	Yes No
Hypersensitive to Heat/Cold	Yes No	Recent Weight Loss or Gain	Yes No	Previous Surgeries	Yes No
Asthma	Yes No	HIV/Aids	Yes No	Metal in Body/Surgical Implants	Yes No
Shortness of Breath	Yes No	Hepatitis	Yes No	Depression	Yes No
Chronic Cough	Yes No	Tuberculosis	Yes No	Anxiety	Yes No
Dizziness/Lightheaded	Yes No	Recurrent Infection(s) in past 3 months	Yes No	Smoking	Yes No
Nausea/Vomiting	Yes No	Fever/Chills	Yes No	Other (please describe below)	Yes No

Please explain 'other' significant past medical history and any surgeries: (include if it was for the current condition)

_____

_____

MEDICATION LIST (including prescriptions, over the counter drugs, herbal , mineral and nutritional supplements and vitamins)

Medication/Drug or Supplement Name	Route of Administration	Dosage	Frequency