



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: _____

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: _____ / _____ / _____

GUARANTOR INFORMATION – If Patient Under 18 Years of Age

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

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

For the safety and well-being of our patients, all individuals under the age of 16 must be accompanied by an adult for the duration of treatment. If the patient is under 16 years, the guarantor may waive this requirement by signing below. By signing the guarantor acknowledges and accepts full responsibility for the minor’s attendance at appointments without an accompanying adult.

Signed: _____ Date: _____

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: _____





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 ONE DAY 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. Three or more no show appointments may result in discharge from care.

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.

We reserve the right to charge a fee up to 10% of delinquent balances for accounts that remain unpaid and are subsequently referred to a collection agency.

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

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 _____



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): _____

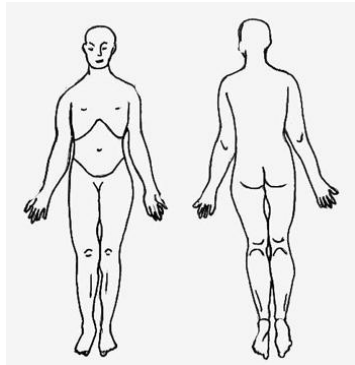
ALLERGIES: List any medication(s) you are allergic to: _____

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*: _____



