Patient Acknowledgement & Release Form

Patient Name: ____ ☐New patient to this facility

☐Change in insurance coverage

Person responsible for payment: __________________________
(if different than patient).

Injury/Diagnosis: ______________________________________

This injury the result of:
□Car accident □Work □Neither

I'M COMING TO PEAK PERFORMANCE BECAUSE: *(Please check all that apply)*

☐ I'm a Former Patient ☐Referred by Friend/Family ☐ Location ☐Website Info ☐I Know PT/Staff ☐Newsletter

☐Online Search ☐Referred by Doctor_____________________________________

I attended ☐Screening ☐Workshop I read ☐Newsletter ☐Website Close ☐Office is close to home

INSURANCE TYPE *(if more than one type, indicate primary and secondary)*

□Aetna □Blue Choice □BC/BS □Cigna □Family Health/Child Health □Self Pay □ MVP ☐ MVP Gold

□Medicare □No-Fault □United Health Care □Workers Compensation □Other _____

I've had ________ PT ______OT _____Speech visits already this year *(same/different body part?)*

The following is a good-faith *estimate* of insurance coverage for Physical Therapy services. It is your responsibility to verify your insurance coverage and eligibility requirements of your particular insurance plan.

□100% coverage □ ______% ins. coverage, ______% patient responsibility

□$______ co-payment per visit □$______ deductible, $______ remaining

□No coverage □$______ *estimated* co-insurance per visit

□Other/Comments: ____

FINANCIAL ACKNOWLEDGEMENT

I, the undersigned:

- Accept financial responsibility for all services rendered to me (or to the patient, if different) by Peak Performance PT;
- Accept personal responsibility for all co-payments, deductibles, and any non-covered services or items for the insurances for which *Peak Performance Physical Therapy* accepts assignment;
- Agree to pay a $20 fee to Peak Performance PT for any returned check (in addition to any fees my bank may charge me);
- Agree to pay all attorney's fees/collection costs to the extent allowed by law for any delinquent account balance;
- Authorize payment of medical insurance benefits directly to Peak Performance Physical Therapy;

Signed ___________________________________ Date_______________

RELEASE OF INFORMATION

"I hereby authorize the referring and/or primary care physician, insurance carrier, or the carrier's specified agent/representative to receive the necessary information pertaining to my treatment as requested to expedite claim payment and/or further authorization for treatment . I also authorize my Physician(s) to send to Peak Peformance and/or receive from Peak Peformance any pertinent information (clinic notes/reports, test results, surgical reports, email/written, verbal and other communications) regarding my condition and treatment in order to optimize my treatment planning and decision making.

Signed ___________________________________ Date_______________

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

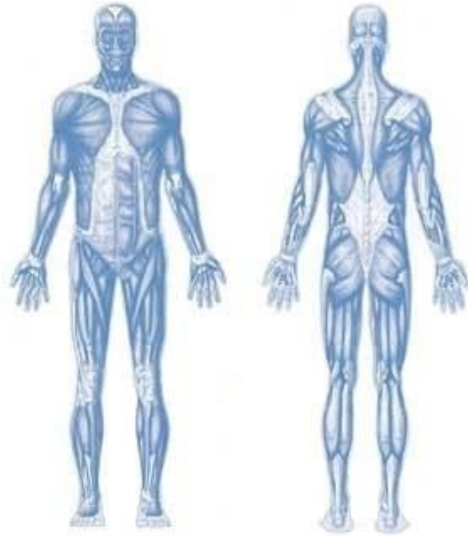
I am familiar with the HIPAA of 1996 document. I am aware that Peak Performance Physical Therapy will abide by the HIPAA guidelines with regard to the privacy of my personal health information. HIPAA document is available upon request.

Signed___________________________________ Date

PEAK PERFORMANCE
Physical Therapy
Sports Training

Past Medical History & Subjective Questionnaire

NAME____ DATE__________________________

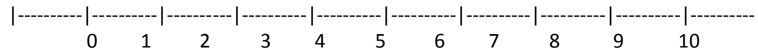


USE THE SYMBOLS BELOW TO SHOW YOUR SYMPTOMS:

"P" = Pain/Ache/Sore
"N" = Numbness
"B" = Burning
"T" = Tingling / Pins & Needles
"U" = Unstable (Giving way)

Within the past week:

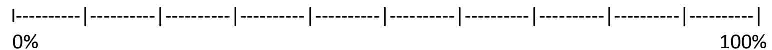
"Absolutely no symptoms" — **"Take me to the hospital"**



0 1 2 3 4 5 6 7 8 9 10

Function Scale

Unable to move body part — **Perform Totally Normally**



0% — 100%

	YES	NO		YES	NO		YES	NO
Diabetes			Autoimmune disease			Shortness of breath/asthma		
High blood pressure			Graves			Dizziness		
Heart disease			Lupus			Neurologic disorder		
Heart attack			Crohne's disease			Psychological treatment		
Stroke			Sjogren's syndrome			Cancer		
Pacemaker			Celiac			Infectious Disease		
Seizures			Connective tissue disease			Are you pregnant?		
Prior Surgery			Bowel/rectal issues			Allergies (heat/ice/latex/adhesive, etc)		
Headaches			Bladder/continence issues			Hernia		
Rheumatoid arthritis			Kidney problems			Metal implant		

Past orthopedic surgeries or injuries:____

____

If ***YES*** to any of the above, please explain and list dates:____

____

Present medication or supplements? ☐ Yes ☐ No
If yes , please list:____

In the past I have had ☐Physical Therapy ☐ Chiropractor ☐Massage ☐Acupuncture

For **THIS** condition I have had ☐Physical Therapy (place:______________________) ☐Chiropractor ☐Acupuncture ☐Massage

The problem I am coming to Physical Therapy for: ☐ Developed gradually ☐Sudden Injury Date of onset:_________________

My symptoms are: ☐Constant (all day long regardless of position or activity) ☐ Intermittent (change with activity or position)

My problem includes: ☐ Giving Way/Buckling ☐ Locking (must shake body part to free up motion) ☐ Pain / Ache / Soreness
(circle all that apply) ☐Catching (gets "hung up" or "stuck") ☐ Weakness/Inability to perform life-work-sport

Things that worsen my symptoms:____

Things that reduce my symptoms:____

I learn best/quickest by ☐Watching/reading ☐Listening/hearing ☐Doing/practicing

CANCELLATION POLICY & COMPLIANCE CONTRACT

I, ____, understand that attending my Physical Therapy appointments, arriving on time, and completing my home exercises are necessary for me to recover. These also optimize my Physical Therapist's ability to effectively help me recover quickly. I understand that No Shows and late Cancellations also may prevent other patients who are on a "waiting list" from completing their plan of care also.

My Physical Therapy program is important to me and I agree to call Peak Performance with 24 hours' notice if I am unable to attend as planned due to an emergency or other reason. In the unlikely event I must cancel with less than 24 hours' notice I will call the office as soon as possible. As is standard in most healthcare providers' offices, I accept that Peak Performance will charge me a cancellation fee of $30.00. Peak Performance will charge a fee of $30 for:

- Cancelled visit with < 24 hours' notice.
- No Show for scheduled visit.

We appreciate your call in advance whenever scheduled dilemmas arise. We will work with you as best we can to make adjustments to help avoid these fees.

I accept that violating the standards of this agreement may be grounds for discontinuation of my Physical Therapy treatments and plan of care, regardless of my insurance coverage/type. I acknowledge that my Physical Therapist has sole discretion in such cases. I want to maximize my potential for reaching my recovery goals.

_________________________________ _______________________

Patient Signature Date

_________________________________ _______________________

Parent Signature Date