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
□$_____ co-payment per visit
□No coverage
□Other/Comments: _____

□ _____% ins. coverage, _____% patient responsibility
□$_____ deductible, $_____ remaining
□$_____ *estimated* co-insurance per visit

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.

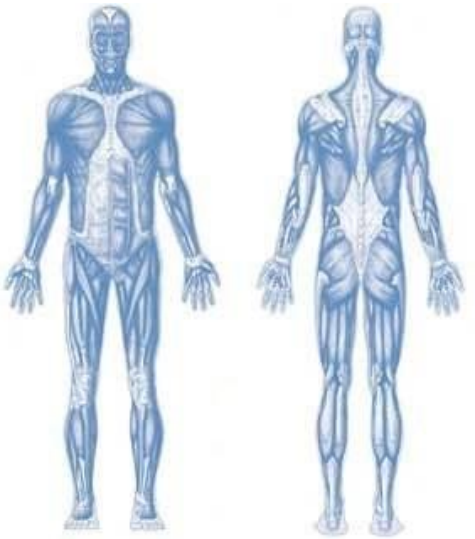
Signed _____ Date_____

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

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