120 Keene Road
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Confidential Patient Health Record

Today's Date: ____________________

How did you hear about us? ☐ **Family** ____________ ☐ **Friend** ____________ ☐ **Co-Worker** ____________
☐ **Close to home/work** ☐ **Dr.** ____________ ☐ **Yellow pages** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**

Personal Information

Last: ____________________ **First:** ____________________ **Middle:** ____________

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** **Name of Parent if patient is a minor:** ____________________

Race: ☐ **Caucasian** ☐ **Hispanic** ☐ **Asian** ☐ **African American** ☐ **Decline to answer** ☐ **Other:** ____________

Ethnicity: ☐ **Caucasian** ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to answer**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **French** ☐ **Other** ____________

Birth Date: ____/____/______ **Age:** ______ **Sex: Male / Female** **SSN:** ____________________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** **Children: #** ______

Mailing Address: ______________________________ **Apt #** ____________

City: ____________________ **State:** ____________ **Zip:** ____________

Cell Phone: (______) ______-________ **Home Phone:** (______) ______-________

Email Address: ____________________ **Spouses Name:** ____________________

I would like my appointment reminders sent to my cell phone via SMS text message. ☐**YES** ☐**NO**

Cell Provider: ☐ **AT&T** ☐ **Cingular** ☐ **Cricket** ☐ **Sprint** ☐ **T-Mobile** ☐ **Verizon** ☐ **Virgin Mobile**
Note: ☐ **US Cellular** does not work with our texting system at this time.
By checking Yes, I am also implying that I understand that standard text message rates will apply and punctual texts are not guaranteed.

Employment Information

Business Name: ______________________________

Occupation/Job Title: ____________________ **Job Description** ____________________

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es))** ☐ **Myself ONLY**

☐ **Spouse** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Other (be specific):** ____________

☐ **Check if you have provided us with a copy of your Insurance Card and skip questions below:**

Personal Health Insurance Carrier: ____________________ **ID Card #:** ____________________

Policy Holder's Name: ____________________ **Group #:** ____________________

Policy Holder's Date of Birth: ______-______-______ **Primary Care Physician:** ____________________

Initial Self-Evaluation

Please take a moment to fill out the following questions as accurately and truthfully as you are able. This information will greatly improve our ability to understand your problems. If you need any assistance with any part, please contact the front desk upon checking in for your appointment.

Date___/___/_____ **Name**______________________________ **Age**______ **Sex** M / F

Marital Status S M D W **Race**_______________ **Education** HS / College / Grad

Occupation______________________________ **Currently Working?** Yes / No

Work Demands ____

Current Work Restrictions______________________________________

History of Current Injury **Date of Injury or Estimated Onset** ____/____/______
Date of Surgery ____/____/______

Cause of injury/symptoms_______________________________________

____

Tell me about about your symptoms Please use the diagram to indicate the location of your symptoms and check the appropriate words below that best describe your symptoms

___ Dull Ache	___Sharp/Stabbing	___Stiffness
___Burning	___Numbness/Tingling	___Radiating
___Throbbing	___Constant	___Intermittent
___Weakness	___Swelling	___Bruising

Other:____

Rate the severity of your symptoms on a scale of 0 to 10. (0= no symptoms, 10 = severe requiring visit to ER)

Current ____/ 10 **Worst**____/10 **Best**____/ 10

Are your symptoms getting ____Better ____Worse ____Same

Do your symptoms ease when you rest in a comfortable position? ___Yes ___No

Do your symptoms disrupt your sleeping? ___Yes ___No

Have you recently had a fever, infection, or other illness? ___Yes ___No

Aggravating factors____

Easing factors____

Previous treatments for this condition

- ❑ Injections
- ❑ Medications
- ❑ Physical Therapy
- ❑ Home Health
- ❑ Other body work ____________________

Previous treatments made me:

___Better ___Worse ___Same

Medical History *Please check below if you have been diagnosed with or received medical treatment for any of the following conditions?*

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Condition
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ Stroke or TIA
- ❑ Cancer ____________________
- ❑ Seizure or Epilepsy
- ❑ Rheumatoid Arthritis
- ❑ Other Arthritic Conditions ____________
- ❑ Osteoporosis or Osteopenia
- ❑ Neurological Condition ____________
- ❑ Severe Headache or Migraine
- ❑ Dizziness or Frequent Falls
- ❑ Thyroid Condition
- ❑ Kidney Disease
- ❑ Bowel or Bladder Disorder
- ❑ Circulatory Problems or DVT
- ❑ Peripheral Neuropathy
- ❑ Anemia
- ❑ Asthma
- ❑ Pulmonary Condition
- ❑ Smoking ____ packs per day
- ❑ Alcohol or Chemical Dependency
- ❑ Depression
- ❑ Anxiety
- ❑ Fibromyalgia
- ❑ Prior Fractures ____________________
- ❑ Latex Sensitive
- ❑ Hearing Loss
- ❑ Vision Problems
- ❑ Sleep Disorder ____________________

Recent Diagnostic Studies

- ❑ X-Ray
- ❑ MRI
- ❑ Bone Scan
- ❑ CT Scan
- ❑ EMG

Results ____________________

____

____

Prior Surgeries *Please list with approximate date*

____

____

____

____

Recent Hospitalizations *Please describe with approximate date*

____

____

____

____

Family History *Has anyone in your immediate family ever been diagnosed with the following?*

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Condition
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritic Condition
- ❑ Anemia
- ❑ Kidney Disease
- ❑ Mental Illness
- ❑ Alcohol or Chemical Dependency

When was your last general physical exam? ___/___/_____ **Physician:**__________________

Do you ever feel unsafe in your home or threatened by a family member? ___Yes ___No

Are you now or could you possibly be Pregnant? ___Yes ___No # of weeks:______

Any recent changes in sleep quality, energy level, or appetite? ___Yes ___No

Have you recently been feeling down or uninterested in things you enjoy? ___Yes ___No

Regular Caffeine Intake? ___beverages per day **Alcohol Intake?** ___drinks per week

Do you regularly exercise? ___Yes ___No **# of days/week:** ____

Please mark any of the following that are New or Unusual for you:

- ❑ Unexplained weight loss/gain
- ❑ Night sweats
- ❑ Difficulty breathing
- ❑ Regular cough
- ❑ Heartburn / indigestion
- ❑ Heart racing/palpitations
- ❑ Excessive bleading or easy bruising
- ❑ Skin rash
- ❑ Constipation / diarrhea
- ❑ Blood in stools or urine
- ❑ Problems urinating or incontinence
- ❑ Arm or leg swelling

Are you currently taking any of the following Over The Counter medications?

- ❑ Aspirin
- ❑ Advil, Motrin, or Ibuprofen
- ❑ Aleve
- ❑ Decongestants or Antihistamines
- ❑ Supplements /Vitamins______________________________
- ❑ Herbal Medicines ______________________________
- ❑ Other ______________________________
- ❑ Tylenol
- ❑ Antacid
- ❑ Laxatives

Please list your current Prescription medications______________________________

____

Describe your normal recreational activities______________________________

____

What are your rehabilitation goals?______________________________

____

How did you hear about us? __Physician __Internet __Insurance Co __Personal Referral____________

Thank you for taking the time to tell me about your symptoms and medical history.
I look forward to discussing them further with you.

______________________________ ______________________________
Patient/Guardian Signature Date Therapist Signature Date

Patient Name: ______________________________ Date: ______________

Notice of Privacy Practices, Acknowledgement and Consent

I consent to the use or disclosure of my protected health information by Peak Performance Physical Therapy for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Peak Performance Physical Therapy may be conditioned upon my consent as evidence by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. I have the right to revoke this consent, in writing, at any time except to the extent that Peak Performance Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to a copy of the Notice of Privacy Practices of Peak Performance Physical Therapy prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Peak Performance Physical Therapy. Peak Performance Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by personal request at the time of my next appointment.

Patient Signature:______________________________________ **Date:**____________

Parent or Guardian: ____________________________________ **Date:**____________

Patient Name: ________________________________ Date:______________

Office Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the doctors of the practice and the patient or the patient parent/ guardian. We must emphasize that as Physical Therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility. Therefore, it is your responsibility for you to know what benefits your insurance plan provides for you.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY

All co-payments are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. It is the responsibility of the patient to provide accurate and timely insurance information. All insurance carriers have a fee schedule from which they will reimburse and not all services provided by this office are covered benefits in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.

NON INSURANCE PATIENTS-TIME OF SERVICE

Charges paid at time of service will be discounted. If we are to bill you, the discounted fee will no longer be offered and you will be responsible the full amount for your visit.

BILLING

Outstanding balances are due within 30 days, unless prior arrangements have been made with the billing department. If no payment has been made on your balance within 90 days a payment notice will be sent to you and if within 15 days you have not contacted our office to pay or set up payment arrangements a 10% rebilling fee will be added to your balance. A letter will be issued at 120 days late. Balances not paid in full within 10 days of the date on the final request letter will be forwarded to our collection agency. * If it becomes necessary to forward your account to a collections agency, you will also be responsible for the fee(s) charged by the agency for the costs of the collection in addition to the original amount due.

A $35 fee will be charged for all returned checks and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.

THE FINANCIAL AGREEMENT

I have read and fully understand the financial policy set forth by Peak Performance Physical Therapy, PLLC. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the guarantor.

____ **Date:**__________

Signature of Patient or Parent/ Responsible Person: