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**

By checking Yes, I am also implying that I understand that standard text message rates will apply and punctual texts are not guaranteed.

Primary Care Physician Name: _____ **Clinic:** _____

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** ☐ **LNI** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Other (be specific):**_____

LNI or Worker's Comp Claim #: _____ **Is claim open?** ☐**YES** ☐**NO** ☐**UNKOWN**

☐ **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:** _____

Patient Name: _____ Date:_____

Current Health Condition

(Why you are here today): _____

_____

PLEASE CIRCLE ON THE DIAGRAM THE AREA OF DISCOMFORT

HISTORY OF CURRENT INJURY

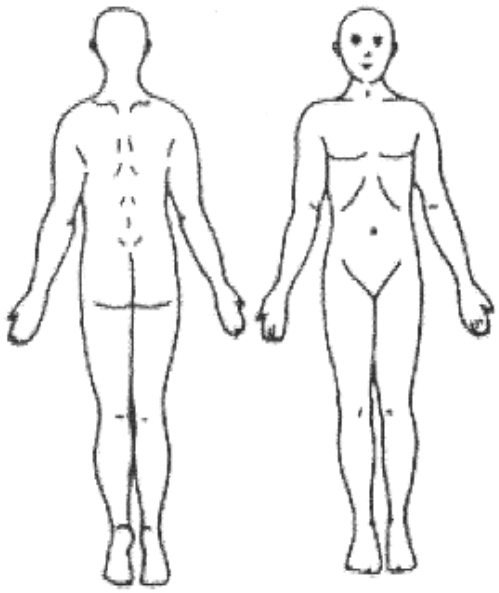
Date of Injury or Estimated Onset? _____/_____/_____
Date of Surgery? _____/_____/_____

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Cause of Injury/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

Have you recently had a fever, infection, or other illness? ___ Yes ___ No

Aggravating factors: _____

Easing factors: _____

Patient Name: _____ Date:_____

Previous treatments for this condition:

- ☐ **Injections**
- ☐ **Medications**
- ☐ **Home Health**
- ☐ **Physical Therapy**
- ☐ **Other body of 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 _____**
- ☐ **Other _____**

Recent Diagnostic Studies:

- ☐ **X-Ray**
- ☐ **MRI**
- ☐ **Bone Scan**
- ☐ **CT Scan**
- ☐ **EMG**

Results:
_____
_____
_____

Prior Surgeries: Please list with approximate date(s)

_____ _____

_____ _____

Recent Hospitalizations: Please describe with approximate date(s)

_____ _____

_____ _____

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**

Patient Name: _____ Date:_____

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 day*

Do you regularly exercise? _____ Yes _____ No

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 bleeding or easy bruising**
- ☐ **Skin rash**
- ☐ **Constipation/ diarrhea**
- ☐ **Blood in stools or urine**
- ☐ **Problems urinating or incontinence**
- ☐ **Arm or leg swelling**
- ☐ **Alcohol or Chemical Dependency**

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 _____

Patient Print Name: _____

Patient's Signature: _____ Date: _____

Patient Name: _____ Date:_____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ___/___/___

Witness: _____ 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:_____

I, the undersigned, do hereby agree and give my consent for Peak Performance Physical Therapy, to furnish the physical therapy treatment considered necessary and proper in assessing or treating _____'s physical condition.

Parent/Guardian _____ Date: ___/___/___

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including that from private insurance and third-party payers to Peak Performance Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Parent/Guardian _____ Date: ___/___/___

Financial Policy Statement

Peak Performance Physical Therapy will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payment made, you will be responsible for the amount of money refunded to your insurance company.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit same to Peak Performance Physical Therapy.

The above does not apply for those claims considered under Workers Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to Peak Performance Physical Therapy, including court costs, collection fees, and attorney fees.

Estimated Insurance Benefits: _____
Estimated Patient Payment: _____

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ Date: ___/___/___
Responsible Party Signature

_____ Date: ___/___/___
Responsible Party Signature

Patient Name: _____ Date:_____

We would like to thank you for choosing us as your physical therapy provider. Our staff will make every effort to ensure that your experience in our office is a positive one. Because of this, we would like to be as efficient as possible in giving you the best care available. Our office uses an automated text reminder system to verify/remind you the business day before your scheduled appointment. Therefore, it is necessary for you to notify the office within **24 hours to cancel** or reschedule an appointment date. A **fee of $50.00 will be assessed** to patients who do not cancel or reschedule within the critical notification time frame.

Should you have any questions or concerns please do not hesitate to ask any of the front office staff, they would be more than happy to assist you. Thank you for your cooperation and understanding in this matter. We look forward to providing you with the best care possible.

_____ _____

Printed Patient Name Date Signed

_____ _____

Patient Signature Witness Signature