



114 Keene Road  
Richland, WA 99352

Phone: (509)579-5844  
Fax: (509)579-0144

### Confidential Patient Health Record

Today's Date: \_\_\_\_\_

#### Personal Information

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Name of Parent if patient is a minor: \_\_\_\_\_

Preferred Language:  English  Spanish  Other \_\_\_\_\_ Interpreter Needed?  YES  NO

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Mailing Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Text message appointment reminders  YES  NO Permission to leave detailed voicemails:  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: \_\_\_\_\_

#### Current Health Condition

**PLEASE CIRCLE ON THE DIAGRAM THE AREA OF DISCOMFORT**

#### HISTORY OF CURRENT INJURY

Area of Injury: \_\_\_\_\_

Date of Injury or Estimated Onset? \_\_\_/\_\_\_/\_\_\_

Date of Surgery? \_\_\_/\_\_\_/\_\_\_

Surgeon? \_\_\_\_\_

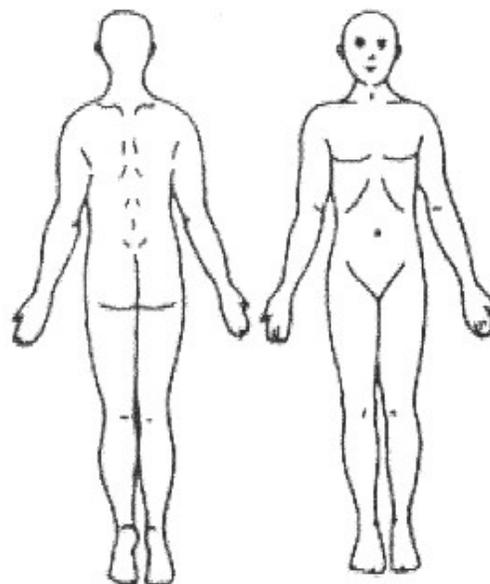
Is the Condition:  Auto Related  Job Related  Home Injury

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

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.

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

**Prior Surgeries/ Recent Hospitalizations:** Please list with approximate date(s)

_____	_____
_____	_____

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

- |   |  |
|---|--|
| <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Excessive bleeding or easy bruising |
| <input type="checkbox"/> Night sweats                 | <input type="checkbox"/> Skin rash                           |
| <input type="checkbox"/> Difficulty breathing         | <input type="checkbox"/> Constipation/ diarrhea              |
| <input type="checkbox"/> Regular cough                | <input type="checkbox"/> Blood in stools or urine            |
| <input type="checkbox"/> Heartburn/ Indigestion       | <input type="checkbox"/> Problems urinating or incontinence  |
| <input type="checkbox"/> Heart racing/ palpitations   | <input type="checkbox"/> Arm or leg swelling                 |
|   | <input type="checkbox"/> Alcohol or Chemical Dependency      |

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 Number 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

Current prescription medications: \_\_\_\_\_

Patient Print Name: \_\_\_\_\_

Patient's 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 evidenced 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.

I understand that Peak Performance Physical Therapy is an open gym and all evaluations and follow up appointments are not held in a private room.

### Medical Information Release Form (HIPAA Release Form)

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

**This information may be released to:**

Name: \_\_\_\_\_ Relation:  Spouse  Child  Other \_\_\_\_\_

Name: \_\_\_\_\_ Relation:  Spouse  Child  Other \_\_\_\_\_

**Information is not to be released to anyone.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

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.

**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.**

### Cancellation or Reschedule Policy

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 two business days 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 **\$85.00 will be assessed** to patients who do not cancel or reschedule within the critical notification time frame. This is not covered by insurance. Should you cancel or miss 3 straight appointments, you will be discharged as a patient and your care turned back over to your referring physician.

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.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_