PEAK PERFORMANCE PHYSICAL THERAPY

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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

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

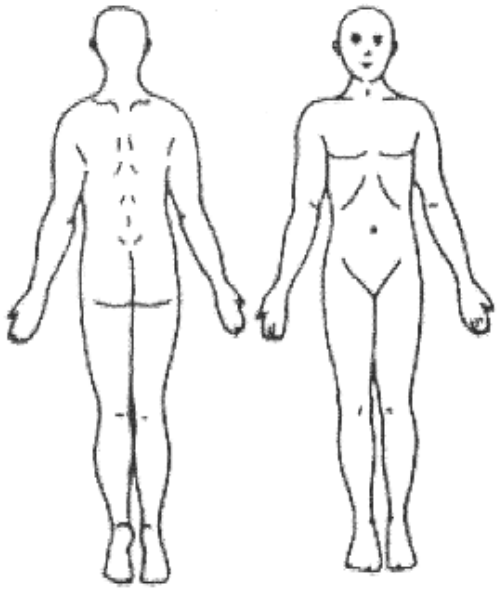
HISTORY OF CURRENT INJURY

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** □ **Physical Therapy**
□ **Medications** □ **Other body of work**
□ **Home Health** **_____**

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 _____**

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

_____ _____

_____ _____

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**

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 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.

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 **$50.00 will be assessed** to patients who do not cancel or reschedule within the critical notification time frame. This is <u>not</u> 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: _____