

# PEAK PERFORMANCE PHYSICAL THERAPY CLINIC

## PATIENT INFORMATION FORM

(PLEASE PRINT LEGIBLY)

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Sex: Male/Female Date of Birth: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Can we contact you at work? Yes No

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Medicare patient's only:** Have you had any home health visits in 2009? Yes / No

If yes, who was the provider? \_\_\_\_\_

How did you hear about us? (circle one) Friend/family Newspaper Phonebook Physician

Whom may we thank for referring you to us? \_\_\_\_\_

E-mail address (appt reminders, newsletter, etc.) \_\_\_\_\_

### **EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **RESPONSIBLE PARTY:** *(needed only if patient is a minor)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **ACCIDENT/INJURY INFORMATION**

Is your injury due to an On-The-Job injury or Motor Vehicle Accident? If yes, check appropriate box:

On-the-job  Auto

Date of accident: \_\_\_\_\_ **(ON THE JOB OR MOTOR VEHICLE INJURIES ONLY)**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Claim Number: \_\_\_\_\_

### **PRIVATE INSURANCE INFORMATION**

Name of Insured: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### **PHOTO IDENTIFICATION PROVIDED** (To be completed by Staff)

Type of ID: \_\_\_\_\_

ID Number: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

By signing, this form, you acknowledge that an employee of Peak Performance Physical Therapy has verified your identification for your protection.

# PEAK PERFORMANCE PHYSICAL THERAPY CLINIC

## GENERAL MEDICAL HISTORY

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

**Are you currently working?** YES NO Type of work: \_\_\_\_\_  
If not, why? \_\_\_\_\_

**Please check (X) if you have had problems with or been treated for:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart problems                     | <input type="checkbox"/> Difficulty Swallowing          | <input type="checkbox"/> Kidney Disease                                  |
| <input type="checkbox"/> Fainting or Dizziness              | <input type="checkbox"/> A Wound that does not Heal     | <input type="checkbox"/> Liver Disease                                   |
| <input type="checkbox"/> Shortness of Breath                | <input type="checkbox"/> Unusual Skin Coloration        | <input type="checkbox"/> Weakness or Fatigue                             |
| <input type="checkbox"/> Calf Pain with Exercise            | <input type="checkbox"/> Lung Disease/Problems          | <input type="checkbox"/> Hernias   |
| <input type="checkbox"/> Severe Headaches                   | <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Blurred Vision                                  |
| <input type="checkbox"/> Recent Accident                    | <input type="checkbox"/> Swollen and Painful Joints     | <input type="checkbox"/> Circulatory Problems                            |
| <input type="checkbox"/> Head Trauma/Concussion             | <input type="checkbox"/> Irregular Heart Beats          | <input type="checkbox"/> Jaw Problems                                    |
| <input type="checkbox"/> Muscular Weakness                  | <input type="checkbox"/> Stomach Pains or Ulcers        | <input type="checkbox"/> Pregnancy                                       |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Pain with Cough or Sneeze      | <input type="checkbox"/> Bowel/Bladder Problems                          |
| <input type="checkbox"/> Joint Dislocation(s)               | <input type="checkbox"/> Back or Neck Injuries          | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Broken Bone                        | <input type="checkbox"/> Stroke(s)                      | <input type="checkbox"/> Balance Problems                                |
| <input type="checkbox"/> Difficulty Sleeping                | <input type="checkbox"/> Muscular Pain with Activity    | <input type="checkbox"/> Swollen Ankles or Legs                          |
| <input type="checkbox"/> High blood pressure (Hypertension) | <input type="checkbox"/> Frequent Falls                 | <input type="checkbox"/> Tremors   |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions      | <input type="checkbox"/> Chest Pain or Pressure at Rest | <input type="checkbox"/> Night Pain (while sleeping)                     |
| <input type="checkbox"/> Constant Pain Unrelieved by Rest   | <input type="checkbox"/> Nervous or Emotional Problems  | <input type="checkbox"/> Unexplained Weight Loss                         |
| <input type="checkbox"/> Constant Pain or Pressure          | <input type="checkbox"/> Pacemaker/Implanted Stimulator | <input type="checkbox"/> Any infectious Disease<br>(TB, AIDS, Hepatitis) |
- Tingling, Numbness, or Loss of Feeling? If yes, where? \_\_\_\_\_  
 Allergies (latex, medication, food) \_\_\_\_\_  
Other \_\_\_\_\_

**Do you use tobacco?** YES NO If yes, how much? \_\_\_\_\_

**Are you presently taking any medications or drugs?** YES NO  
If yes, what are you taking them for? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any surgeries or other conditions for which you have been hospitalized:**

<u>DATE</u>	<u>SURGERY/REASON</u>
_____	_____
_____	_____
_____	_____

**Have you recently had an X-ray, MRI, or CT scan for your condition?** YES NO  
DATE AREA  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you been evaluated and/or treated by another physician, physical therapist, chiropractor, osteopath, or health care practitioner for this condition?** YES NO  
If yes, please list: \_\_\_\_\_

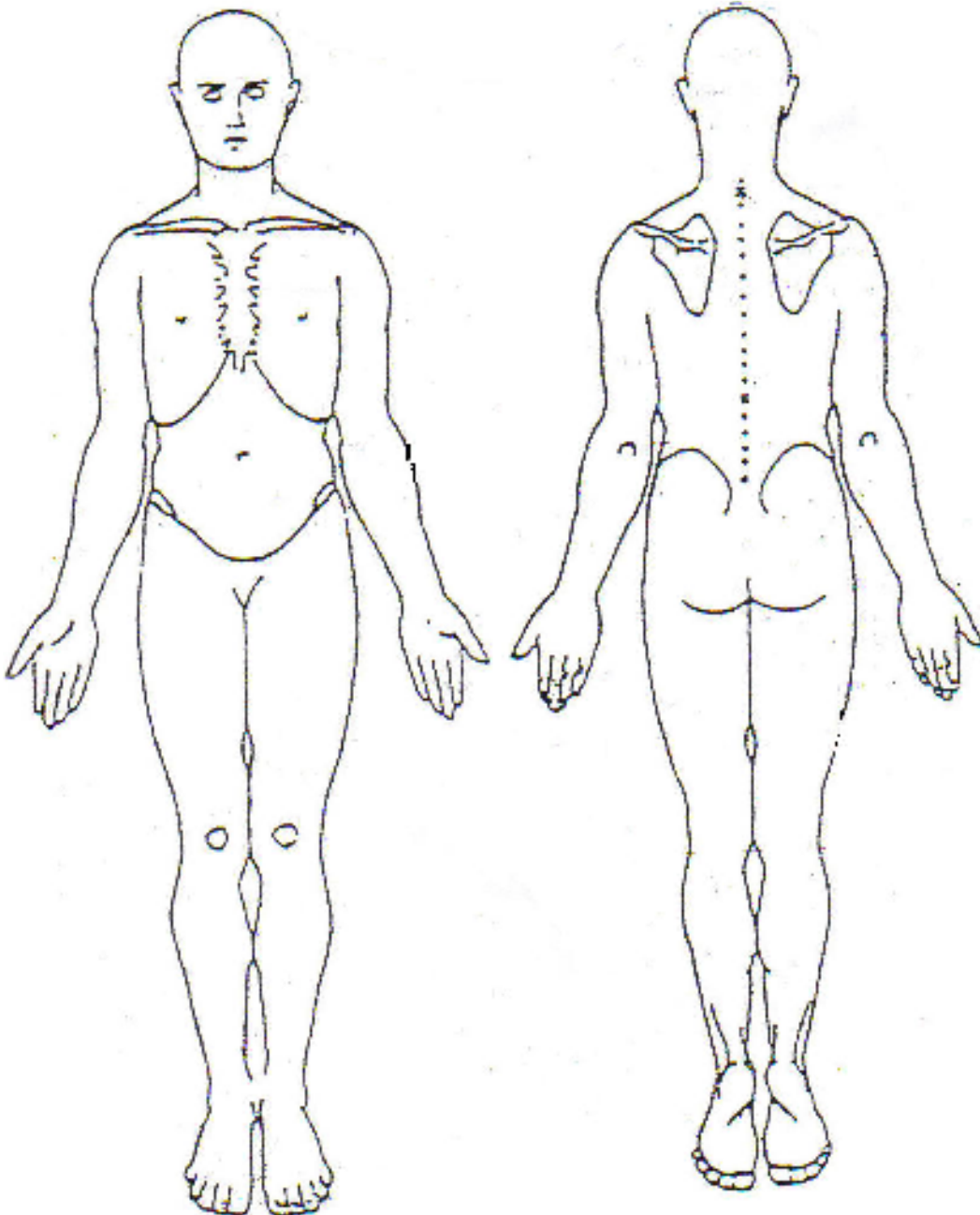
# PEAK PERFORMANCE PHYSICAL THERAPY CLINIC

## GENERAL MEDICAL HISTORY

- 1) Current Level of Pain, on a scale of 0 to 10 \_\_\_\_\_. (0 = no pain, and 10 = worst pain imaginable)
  - 2) Score your current ability to perform simple movements with your involved region, \_\_\_\_\_.  
(0 = normal movement, and 10 = unable to move your involved region at all.)
  - 3) Function: Score your current ability to perform your activities of daily living, \_\_\_\_\_.  
(getting out of a bed or a chair, driving, getting dressed, etc.)  
(0 = able to perform ALL normal activities, and 10 = unable to perform ANY of your normal daily activities.)
- 

Please Mark the Area that is experiencing Pain or Numbness:

- X = Pain
- ✎ = Numbness/Tingling
- ▽ = Area of Weakness



# PEAK PERFORMANCE PHYSICAL THERAPY CLINIC

## NOTICE OF PRIVACY POLICIES

Our commitment at Peak Performance Physical Therapy is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information (PHI). During the course of treatment it may be necessary to share information with other medical providers or associates. We are committed to obeying all Federal and State laws and regulations regarding PHI, and information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF PRIVACY PRACTICES. \_\_\_\_\_

*(Please initial)*

## ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance carrier to pay by check, made out and mailed to:

**Peak Performance Physical Therapy, 450 NW Greenwood Ave., Redmond, OR 97756**

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Peak Performance Physical Therapy, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment in accordance with my current policy guidelines.

I HAVE READ AND UNDERSTAND THE ABOVE ASSIGNMENT OF BENEFITS. \_\_\_\_\_

*(Please initial)*

## AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY AUTHORIZE Peak Performance Physical Therapy to release my health care information including but not limited to testing, diagnosis, and/or treatment plans to my insurance company, adjuster, attorney, Worker's Compensation carrier, and/or to my referring physician or any physician that assists in the administration or the continuation of my plan of care.

I HEREBY AUTHORIZE any health care provider to release my personal health information as it pertains to my rehabilitative care if any is requested by Peak Performance Physical Therapy.

I HEREBY AUTHORIZE Peak Performance Physical Therapy to initiate a complaint to the Insurance Commissioner in the State of Oregon for reasons pertaining to the process of submitting claims or appropriate legal and ethical collection on my behalf.

\_\_\_\_\_  
Patient Signature (or Responsible Party)

\_\_\_\_\_  
Date

# PEAK PERFORMANCE PHYSICAL THERAPY CLINIC

## FINANCIAL POLICY FOR MOTOR VEHICLE ACCIDENTS

Peak Performance Physical Therapy is committed to providing you quality, rehabilitative healthcare services. We support our staff and stand behind all the therapy programs developed for our patients, since our number one goal is to improve their health and wellbeing. Our client-therapist relationship must be based on open and honest communication, therefore, we request you read through the following policy and understand the financial responsibilities we both have. The information is being presented to you in order to clarify our expectations and prevent any possible misunderstandings concerning the status of your account. If you have ANY questions, concerns or comments regarding this policy, please bring it to the attention of one of our office staff members and we will do our best to resolve the issue.

**Cancellation Policy:** We request that notification be given at least 24-hours in advance when an appointment must be cancelled or rescheduled. We realize that emergencies and scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our unique one-hour appointment scheduling system, missed appointments without notification are a significant inconvenience to the therapist, the clinic and other patients. **Therefore, Peak Performance Physical Therapy reserves the right to charge your account a \$25.00 service charge for missing an appointment without 24-hour notification. This fee is not a covered expense under your insurance policy and will be billed to you directly.** After missing two appointments without proper notification, the clinic reserves the right to place you on a same-day scheduling policy; which means appointments, if available, can only be scheduled on the day you call. No advance appointments will be scheduled.

**Insurance:** It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. *If we do not have verifiable billing information within three clinic visits*, your therapy program will continue only on a cash basis until we receive the necessary billing information pertaining to your accident or obtain private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private health insurance for the services; but ultimately you will be responsible for full payment. We do not accept attorney "letter of protection" for claims being disputed or in litigation. In that instance we will need alternate insurance information or you can make arrangements to set your account up on a "cash" basis.

**Workers Compensation:** It is our goal to formulate a plan of care that maximizes your ability to return to work in accordance with your physician recommendations. We will work closely with your health care provider(s) to ensure that the program we design for you fits your capabilities and tolerance levels. How effective your personal plan is depends on several things: your ability to attend the necessary appointments recommended by your therapist and physician; your ability to perform the assigned exercises, and your overall tolerance to the therapy program. It is imperative that you maintain an open dialogue with your therapist so that everyone involved in your case can be kept informed of your progress.

**SAIF:** For those patients who have SAIF handling their workers compensation claims, we will need to ensure the claim is not part of their managed care organization Oregon Health Systems (OHS). OHS will not allow us (Peak Performance PT) to participate in their panel of therapists due to demographic and population issues in the Redmond area. They will not pay for any therapy we administer to patients enrolled in this plan. ***If you have information on your enrollment, or possible enrollment, with OHS please notify us immediately.***

**Motor Vehicle Accident:** MVA claims are handled through your personal auto insurance, regardless of who was at fault in the accident. If someone else was responsible for your accident, we understand their insurance will be covering your medical expenses, but it is standard industry practice to bill your insurance first so they can maintain accurate records on your behalf and work to have those expenses reimbursed in a timely fashion. If your insurance is covering all expenses, we will verify your PIP (personal injury protection) benefit to ensure you have that available coverage. If your PIP is exhausted, we can bill your private insurance for any remaining balance not covered. We will not put any accounts on hold, accept any letter of protection or wait for any litigation to be complete before obtaining reimbursement. ***Please notify us immediately of any insurance coverage changes.***

***I have read and understand the financial policy of this office and agree that, regardless of my insurance coverage, I am ultimately responsible for full payment of my account.***

\_\_\_\_\_  
Patient Signature (or Responsible Party)

\_\_\_\_\_  
Date