

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
(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:

DATE SURGERY/REASON

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

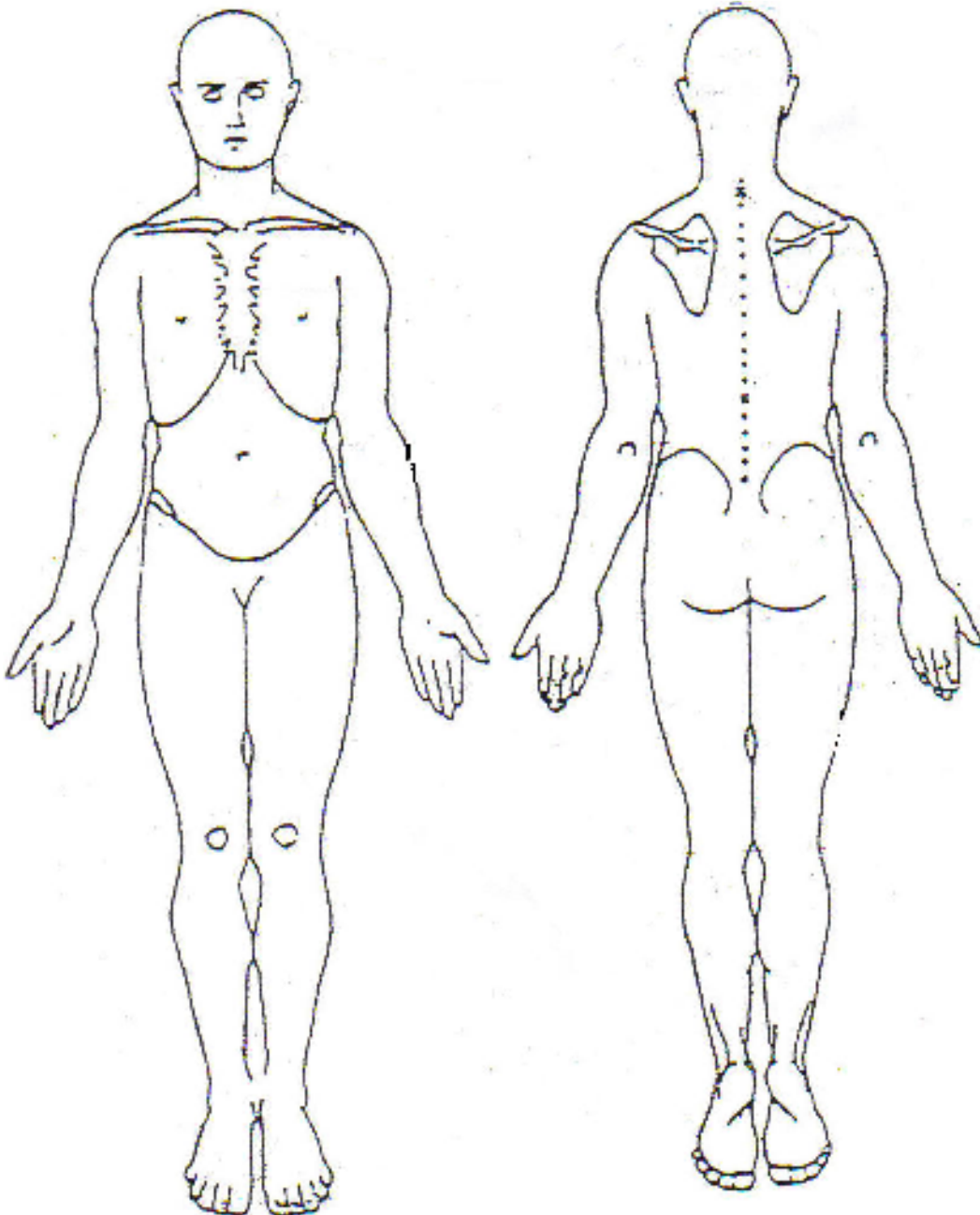
- 1) Current Level of Pain, on a scale of 0 to 10 _____. (0 = no pain, and 10 = worst pain imaginable)
 - 2) Score your current ability to perform simple movements with your involved region, _____.
(0 = normal movement, and 10 = unable to move your involved region at all.)
 - 3) Function: Score your 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 PRIVATE INSURED

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.

Medical Insurance Coverage: Our providers participate in the majority of regional health plan networks, allowing you the benefit of in-network reimbursement rates. After obtaining a copy of your insurance card, we will make every attempt to verify your current insurance coverage. Information we are requesting includes effective dates, deductibles, co-payments and co-insurance amounts. Each patient is given a verification card outlining the coverage quoted. *Verification of benefits is NOT a guarantee of payment.* Any changes in policies, coverage, usage, etc could alter reimbursement rates and benefits.

If we are unable to verify billable insurance within 5 business days, your account will be changed to a CASH status and any balance will be made your responsibility. We will notify you immediately of this change.

Co-payments and deductibles are part of your contractual agreement with your insurance company and it is our responsibility as participating providers, through our contractual agreement as well, to collect those fees. *These amounts will be collected at each visit.* If the insurance company should reimburse more than the verified amount, we will reimburse you immediately upon overpayment.

Monthly Statements: Patients carrying a balance will be sent a statement at the beginning of each month. Payment in full is expected within 10 days. If you have any questions, concerns, or would like to set up a payment plan, please call our billing office to handle those issues. Accounts in current standing will not be assessed any finance charges or billing fees. Account balances carried beyond 120 days will be assessed a monthly finance charge of 1.5% or \$10.00, whichever is greater.

Monthly Payment Plans: As a courtesy to patients who cannot pay their account in full every month, we offer a limited monthly payment plan. All arrangements must be made in advance with our billing department. Minimum payment amounts vary depending on balances, and no plan will extend beyond a 12 month period. Account balances carried beyond 120 days will be assessed a monthly finance charge of 1.5% or \$10.00, whichever is greater.

Collections: Please understand that payment for services is considered *part of your treatment*. Should your account age beyond 120 days without any payment, your information will be sent to a collection agency for further action. Our clinic will make every attempt to contact you for payment on your account before that step is taken. If we are forced to turn your account over to a credit bureau your privacy rights will be forfeited, your account will become part of public records, and neither you nor any family members will be allowed to obtain therapy treatment at our clinic. Additionally, your account will be assessed for any of the collection fees we incur by instigating this process.

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