PEAK
PHYSICAL
THERAPY

PATIENT INFORMATION

NAME______________________________________HOME PHONE____________________________________
ADDRESS____________________________________WORK PHONE____________________________________
CITY/STATE__________________ZIP CODE__________CELLPHONE____________________________________
DRIVER'S LICENSE#____________________________EMAIL ADDRESS________________________________
DATE OF BIRTH_______________________________PATIENT'S GENDER______________________________
EMPLOYER___________________________________EMPLOYER ADDRESS______________________________
EMERGENCY CONTACT___________________________EMERG. CONTACT RELATION TO YOU_________________

RESPONSIBLE PARTY INFORMATION (IF UNDER 18)

NAME OF PARENT GUARDIAN_______________________RELATIONSHIP________________________________
ADDRESS__________________CITY_______________STATE____
HOME PHONE________________WK PHONE___________ HOME/CELL PHONE_____________________________
IS PATIENT A MINOR (UNDER 18) YES/NO IF SO, HOW OLD____

INSURANCE INFORMATION

INSURANCE COMPANY____
ADDRESS__________________CITY_______________STATE_______ZIP________________________________
PHONE NUMBER____
IDENTIFICATION NUMBER/POLICY#____
GROUP #____
PRIMARY INSURED NAME__________________________RELATION TO PATIENT_________________________
PRIMARY INSURED DATE OF BIRTH____
NAME OF REFRRING PROVIDER (M.D, CHIROPRACTOR, ETC.)____

-IF TREATMENT REQUIRED SECONDARY TO **AUTO OR WORK RELATED CLAIM**, PROVIDE INFORMATION BELOW-

(AUTO OR L&I INFORMATION) INSURANCE COMPANY____
CLAIM NUMBER________________________________CLAIM MANAGER'S NAME & PHONE__________________
ADDRESS___________________________________CITY________________STATE______ZIP______________

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND HIPPA

I AUTHORIZE EVALUATION AND TREATMENT AND CONSENT TO PHYSICAL THERAPY SERVICES FROM PEAK PHSICAL THERAPY AS DIRECTED BY MY PHYSICIAN AND OR PHYSICAL THERAPIST. I RECOGNIZE THAT TREATMENT RESULTS ARE DEPENDENT ON MANY FACTORS AND ARE NOT GUARANTEED. **INITIALS HERE**______________________

I AUTHORIZE PEAK PHYSICAL THERAPY TO RELEASE INFORMATION CONCERNING MY TREATMENT, INCLUDING THE REPRODUCTION OF MY MEDICAL RECORDS, FOR EACH THRID PARTY INSURER FROM WHOM I MAY SEEK PAYMENT OR REIMBURSEMENT FOR EXPENSES RELATED TO MY TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION TO REFERRING/CONSULTING PHYSICIANS OR OTHER HEALTH CARE PROVIDERS THAT MAY BE NECESSARY TO ASSIST CARE. **INITIALS HERE**______________________

I AGREE TO PAY ALL CHARGES FOR SUCH TREATMENT THAT MAY OR MAY NOT BE COVERED BY MY INSURANCE AND I AM RESPONSIBLE FOR ANY BALANCE DUE. I FURTHER ASSIGN ALL BENEFITS AND AUTHORIZE PAYMENTS DIRECTLY TO PEAK PHYSICAL THERAPY FOR THE INSURANCE BENEFITS TO WHICH I AM ENTITLED AND WHICH ARE OTHERWISE PAYABLE TO ME. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PEAK PHYSICAL THERAPY. PLEASE NOTE CO-PAYMENTS ARE COLLECTED AT TIME OF VISIT AND COINSURANCE CHAGRES WILL BE BILLED TO YOU AFTER PAYMENT OR EXPLANATION OF PAYMENT HAS BEEN MADE BY YOUR INSURANCE COMPANY. SHOULD PRIOR AUTHORIZATION AND OR REFERRAL BE REQUIRED BY YOUR INSURANCE PROVIDER, IT IS YOUR RESPONSIBLILITY TO ENSURE THAT YOU HAVE INITIATED AND COMPLETED THIS PROCESS. **INITIALS HERE**______________________

I HEREBY ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES (HIPPA) ON THIS DAY. I CERTIFY THAT A COPY OF THE ENTIRETY OF THE ABOVE AGREEMENT SHALL BE VALID AS THE ORIGINAL. **INITIALS HERE**______________________

SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS A MINOR)

X____ **DATE**___________________________

PATIENT NAME PRINTED____