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_____

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PATIENT MEDICAL HISTORY

NAME_____DATE_____

REFERRING PHYSICIAN_____PRIMARY CARE PHYSICIAN_____

REASON FOR SEEKING TREATMENT (INJURY DESCRIPTION)_____

_____

DATE OF ONSET AND OR SURGERY_____

MEDICATIONS (LIST)

1)_____FOR_____

2)_____ FOR_____

3)_____ FOR_____

4)_____FOR_____

5)_____FOR_____

OTHERS_____

MEDICAL HISTORY (CIRCLE BELOW YES OR NO, INDICATE DATE IF SURGERY)

DIABETES	Y	N	RHEUMATOID ARTHRITIS	Y	N
HIGH BLOOD PRESSURE	Y	N	OSTEOARTHRITIS	Y	N
HEART ATTACK	Y	N	OSTEOPOROSIS	Y	N
HEART SURGERY	Y	N	METAL IMPLANTS/WHERE	Y	N
PACEMAKER	Y	N	METAL SCREWS/PINS/PLATES	Y	N
SHORTNESS OF BREATH	Y	N	SPINE FUSIONS	Y	N
CHEST PAIN	Y	N	JOINT REPLACEMENTS/WHERE	Y	N
CANCER HX/LOCATION	Y	N	NECK SURGERY	Y	N
CHEMOTHERAPY	Y	N	BACK SURGERY	Y	N
ASTHMA	Y	N	HIP SURGERY	Y	N
RESPIRATORY DISEASE	Y	N	KNEE SURGERY	Y	N
STROKE	Y	N	ANKLE SURGERY	Y	N
BLOOD CLOT/LOCATION	Y	N	SHOULDER SURGERY	Y	N
SEIZURES/EPILEPSY	Y	N	ELBOW SURGERY	Y	N
CATARACTS	Y	N	SMOKING	Y	N
VISION PROBLEMS	Y	N	KIDNEY DISEASE/STONES	Y	N
HEARING PROBLEMS	Y	N	ULCERS	Y	N
DIZZINESS	Y	N	LIST OTHER SURGERIES_____		
PREGNANT	Y	N	_____		
FRACTURES/WHERE	Y	N	_____		
HERNIA	Y	N	_____		
WEAKNESS	Y	N	_____		

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CURRENT PROBLEM: DO YOU EXPERIENCE ANY OF THE FOLLOWING? (CIRCLE)

NAUSEA	Y N	NUMBNESS/TINGLING	Y N
VOMITTING	Y N	BOWEL OR BLADDER CHANGES	Y N
FEVER/CHILLS/SWEATS	Y N	NIGHT PAIN	Y N
SUDDEN WEIGHT GAIN/LOSS	Y N	HEADACHES	Y N

LIST REGULAR EXERCISE/ACTIVITY

_____

_____

_____

PAST TREATMENT FOR PROBLEM YOU ARE SEEKING TREATMENT FOR TODAY

ORTHOPEDIST	Y N	ACUPUNCTURE	Y N
NEUROSURGEON	Y N	PSYCHOLOGIST	Y N
CHIROPRACTOR	Y N	OTHER PHYSICAL THERAPIST	Y N
MASSAGE THERAPIST	Y N	OTHER_____	

DESCRIBE/LIST HOW PROBLEM INTERFERES WITH DAILY ACTIVITY (WORK, SPORT, ACTIVITIES)

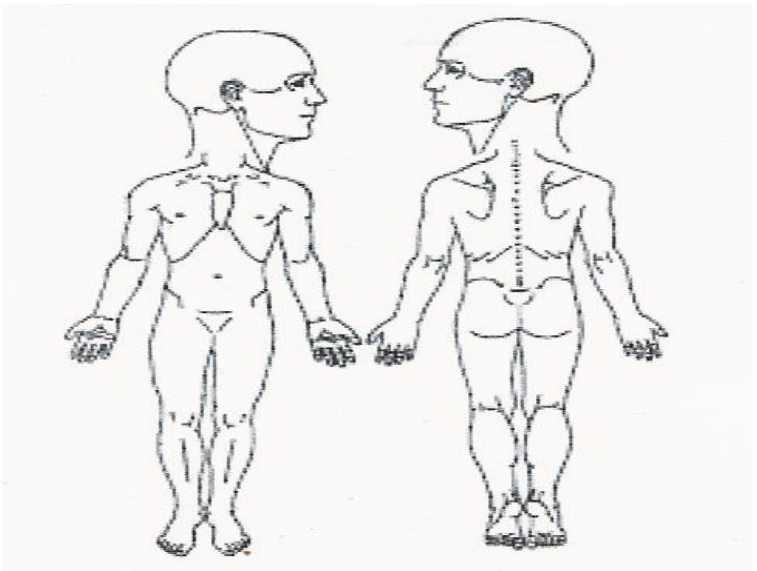
_____

_____

_____

_____

USING DIAGRAM BELOW DRAW X('s) WHERE PAIN IS AND INDICATE PAIN LEVEL ON SCALE OF 1-10,(10=WORST PAIN) (Short Form McGill Pain Pain Diagram)



By signing below I attest the information provided above is true and accurate to the best of my knowledge.

Patient Signature X_____

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Financial Policy

Appointments/Cancellations: Patients are seen by appointment only. Our goal is to give individualized attention and your appointment is very important to us. Should you need to alter your appointment we understand unexpected situations occur; however we require at least 24 hours notice so we may offer that time to another patient and can plan accordingly. **We charge a $60 fee for missed or cancelled appointments not cancelled within 24 hours prior to appointment.** This is to incentivize early planning and allow our clinic to operate smoothly. Be aware this fee cannot be billed to your insurance company so please give early notice for any and all cancellations to allow us to plan our patient care schedule accordingly. If you miss 3 appointments without proper notice, all future appointments may be cancelled. Please arrive on time for your appointment to allow optimal treatment time and prevent disruption of the daily schedule.

Payment options: We will bill your health insurance directly. We are a preferred provider with several major insurance providers. We accept cash, or checks written to Peak Physical Therapy. Private pay is accepted and billed at hourly rate for 1 hour sessions.

Financial Policy: You are financially responsible for all charges including but not limited to co-payments, deductibles and non-covered services. Co-pays and or unmet deductible are due at time of service. It is your responsibility to know your insurance benefits prior to treatment. This will insure that you know and can prevent unexpected costs. If the insurance company requests information from you, it is your responsibility to send it to them. If your information is not received, your claims may denied and you will be responsible for the amount of your bill. If your insurance has not made full payment within 120 days we will bill you the amount owed. Checks returned secondary to insufficient funds will be charged a $35.00 fee. Outstanding balances unpaid after 60 days will accrue a 1% (12% annual) finance charge for each billing cycle. Balances unpaid after 60 days must have a payment plan/arrangement. Outstanding balances unpaid after 90 days will be turned over to collections. Should it be necessary to forward an unpaid balance to a collections agency, you agree to pay interest and collection fees. By signing below you agree to not withhold or delay payment if your insurance company denies payment on any of your charges. Also, by signing below you authorize your insurance benefits to be paid directly to Peak Physical Therapy.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO ABIDE TO THE POLICIES STATED ABOVE.

PRINT NAME HERE_____

X_____

SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION (HIPPA)

This notice describes how medical information about you can be used and disclosed and how you can access this information. Please review it carefully.

We are required by law to maintain the privacy of your protected health information. By law we must provide you with notice of your legal duties and privacy practices relating to protected health information. This notice details your rights with regard to how we may use and disclose your protected health information (PHI) for treatment, payment and healthcare operations and other purposes permitted by law.

Description of (PHI): Your protected health information is health information that contains demographic identifiers,such as name, address, and other information that may reveal your identity and nature of your care.

Permitted uses and disclosures: We may use and disclose you PHI without your written consent for the following:

-Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare treatment among healthcare providers with a third party, consultation between health care providers regarding a patient, or with providers you requested to be involved in your care.

-Payment: the activities of health care providers to obtain payment or reimbursement for their services and to ascertain premiums, covered responsibilities and obtain or provide reimbursement for the provision of healthcare. We use your PHI to confirm your eligibility or insurance coverage under a plan, adjudicating claims, billing and collection activities and justification of charges.

-We may use and disclose your PHI to support our business activities to ensure quality care. These activities include administrative, financial, legal, and quality improvements necessary to operate our business. Such uses and disclosures may occur for licensing, compliance review and management purposes; to review and evaluate our treatment; care services; to train and evaluate staff and obtain legal and financial collection assistance.

-We may use your PHI to market or promote health related benefits and services, to inform you of health related products or services provided by Peak Physical Therapy, other treatments or therapies, or in communication and during interactions with you.

As Required by law: Your PHI may be used and or disclosed without your authorization in the following special circumstances as required by federal, state or local law including; public health authorities related to public health risks or activities, health oversight activities such as audits, investigations, inspections and licensure and activities authorized by law that are necessary for government monitoring of the health care system, government programs and compliance with civil rights laws; reports to appropriate authorities concerning victims of abuse, neglect, or domestic violence.

-We may disclose your PHI in compliance with a court or administrative order, court order, warrant, court subpoena, discovery request or in response to lawful discovery process.

-We may disclose your PHI when requested by law enforcement, coroner, health examiner and funeral directors.

-If you are a member of the armed services PHI may be released as required by military command authorities or the Department of Veterans Affairs as applicable.

-Additionally the release of PHI about foreign military personnel to the appropriate foreign military authorities; to federal officials as required by law for national security activity; to workers compensation or similar programs that provide benefits for work related injuries or illnesses; research,

if conducted without information that could reveal your identity.
-Uses or disclosures of your PHI not covered within this notice or applicable laws may only be made with your written authorization. You may revoke such authorization in writing at any time.
-We may provide relevant PHI to a family member, relative, close friend or any other person you identify as being involved in your treatment decisions or payment responsibilities. You have the right to object to this and notify us your wishes.

Your rights concerning PHI: You have the following rights with respect to medical information:
-You may ask to restrict certain uses and disclosures of your PHI. We are not required to agree to your request and you must submit your request in writing to our business office.
-You have the right to receive communications in a confidential manner.
-You may have the right to review or obtain copies of your PHI. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records. We may deny your request to inspect or receive copies in certain limited circumstances, such as if psychotherapy notes or if a licensed health care professional determines that your access to the information may endanger the life or physical safety of another person. If you are denied access to your PHI in some cases you will have a right to request a review of denial decision.
-You may ask to amend you medical information. Your request must be in writing and state reason you believe the amendment is necessary. We may deny your request for certain specific reasons including denial if your request is not in writing, not accompanied with your reason for the request or if the PHI was not created by us. If we deny your request, we will provide you with a written explanation for the denial. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial which may be attached to your clinical record.
-You have the right to receive an accounting of the disclosures of your medical information made by us during the last six years. Your request must be in writing and must state the time period for the requested information. You may not be entitled to information for dates greater then six years from the timing of your request.
-You may request a paper copy of this Notice of Privacy Practices for PHI.
Complaints: You have the right to complain to us and/or to the United States Department Health and Human Services if you believe we have violated your privacy rights. To file a complaint with us, you must make it in writing within 180 days of suspected violation. Please provide information regarding the suspected violation and send it to our office.
-Changes to Privacy Practices: We reserve the right to make revisions to this notice and to our privacy practices at any time. Revisions will apply to all the PHI we currently maintain, and any PHI that we obtain in the future. If we make material changes to this notice, we will post changes on our website.