Important Information regarding your Medical Insurance

A representative from Peak Motion Physical Therapy has called your insurance company to attempt to obtain your benefit information and any necessary authorizations. Benefit information that is quoted to our representative by your insurance company is not a guarantee of payment. We are under contractual obligation with your insurance company to collect any anticipated co-payments, deductibles, and/or coinsurance amounts at each visit. Payments you make to our office will be applied to your account, and you will be billed for any remaining balance after we have received all expected payments from your insurance company. If you have overpaid, credits will be refunded within thirty days of receiving all anticipated insurance payments. We will file to any applicable secondary insurance companies as a courtesy. We recommend contacting your insurance company or referring to your insurance handbook if you have any questions regarding your physical therapy benefits.

Copayment- A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care. Usually a set amount such as $20, $30, or $40, and will need to be paid at each visit.

Coinsurance - A provision by which the insured individual shares in the cost of certain expenses. In these instances, the insurance pays a percentage of the allowed charges (e.g. 80%), and the patient pays the remaining percentage (e.g. 20%). We will collect $20 at each appointment and you will be billed for any remaining balance at the end of your care.

Deductible - The portion of any claim that is not covered by the insurance provider. It is the amount of expenses that must be paid out of pocket to the provider's office before an insurer will cover any expenses. We will collect $100 at each visit until your deductible has been met. However, your charges may exceed the amount that we collect, and you will be billed for any additional amount that your insurance deems as "patient responsibility". Co-payment or coinsurance rules may take affect after your deductible has been met.

I have read and understand the above information.

Patient / Responsible Party Signature:____

Patient Insurance Information:

Insurance company:____

Policy Holder's Name and Employer:____

Relationship to Policy Holder: ( ) self _____________________ DOB of PH:____________________

Patient SSN:___________________________ Phone Number:______________________________

Patient Address:____

Is your condition due to a **MOTOR VEHICLE ACCIDENT**? ______________ If YES, are you going through your own auto insurance? _______________ If you are going through your personal health insurance, please notify front office staff prior to being seen.

***Please be aware that we do not accept THIRD PARTY LIABILITY INSURANCE OR LITIGATION (LOP).**

PEAK MOTION
PHYSICAL THERAPY,INC.

PATIENT HEALTH HISTORY

Date: ____/____/____

Date of Injury:_______________

❖ *Patient Information*

Patient Name:____

Patient Age:______ DOB: ______/______/______

Mechanism of Injury:__________________________________

Emergency Contact:___________________________________

Occupation:____

Emergency Phone #:__________________________________

❖ *Patient Historv*

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No Reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other:_______

What activities increase pain?

- ☐ Exercise (During)
- ☐ Exercise (After)
- ☐ Sitting
- ☐ Walking
- ☐ No Reason
- ☐ Bending forward
- ☐ Bending Backward
- ☐ Coughing
- ☐ Sneezing
- ☐ Other:________

What activities reduce pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-Inflammatory
- ☐ Pain Pills
- ☐ Injection for pain
- ☐ Muscle Relaxants
- ☐ Nothing
- ☐ Other:________

How long have you had this pain?

____Years ____Months ____Weeks

Have you had any diagnostic tests?

- ☐ X-ray Date:__________
- ☐ CT Scan Date:__________
- ☐ EMG/NCV Date:__________
- ☐ MRI Date:__________
- ☐ Injections Date:__________

Have you had surgery for your problem?

Yes / No : ___________________

Any Surgery: _________________

List your Medication:

____

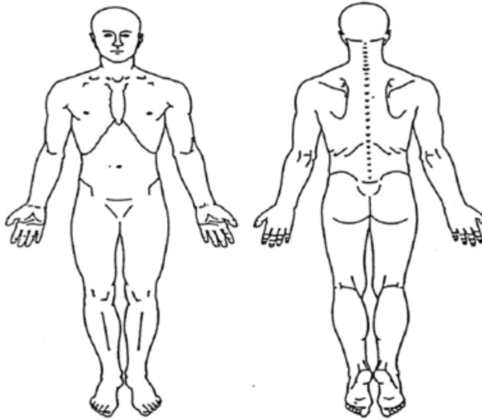
____

____

Pain / Symptoms:

On the Body Diagram, indicate your region of pain using the symbols below.

(X) : Sharp (+): Numb/Tingling (#): Dull/Aching (B): Burning



Rate your Pain:

Pain Level (0-10):_________

0=No Pain & 10= Emergency Room

Place a checkmark for ***YES*** & leave ***BLANK*** for ***NO***.

- ☐ Allergies: __________
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke (CVA)
- ☐ Cancer :__________
- ☐ Pulmonary
- ☐ Arthritis (OA)
- ☐ Arthritis (RA)
- ☐ (Ir)Regular Headaches
- ☐ Dizziness/Blackouts
- ☐ Seizures
- ☐ Bowel/Bladder Issues
- ☐ Asthma/ Breathing Issues
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Hypoglycemia
- ☐ Osteoporosis
- ☐ Sexual Dysfunction
- ☐ Are you Pregnant?
- ☐ Hernia
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Smoker
- ☐ Metal Implants:___________
- ☐ Other: ___________________

Patient Signature:______________________________ : Therapist Signature:__________________________________

PEAK MOTION
PHYSICAL THERAPY,INC.

CLINIC POLICIES

❖ **"WELCOME TO PEAK MOTION OUTPATIENT PHYSICAL THERAPY**. We are pleased you have chosen our service and we will do everything possible to optimize your satisfaction while you are here. Listed below are some policies and suggestions we have in place while you are receiving physical therapy. If you have any questions, concerns or comments, you may inquire with our front office staff; speak with the clinic manager, or request to speak with the owner."

Sincerely,
Philip M. Baca
Philip M. Baca/owner

❖ *Policies*

ATTENDANCE- IF YOU ARE UNABLE TO ATTEND, YOU MUST NOTIFY THE CLINIC IN ADVANCE AND RESCHEDULE TO MAKE UP FOR THE MISSED APPOINTMENT.

- **If you cancel or fail to attend 3 consecutive appointments, it may result in termination of your therapy program**.
- A **$25** no-show/late cancellation charge will be applied to those who **do not** give 24 hours notice.
  - ✓ ***Monday*** appointments must be cancelled prior to 12:00pm Friday.
  - ✓ **Please be aware that insurance will not cover charges for no-shows/late cancellations.**
- **Worker's Compensation:** Your physician, employer, and insurance adjuster will be contacted.

MUSIC-At Peak Motion, music creates what we feel is an important role in setting a positive atmosphere for the clinic setting. In the gym, upbeat music is used to motivate and facilitate exercise. However, at any time, you find the music offensive or would like to request something, please ask any of our staff for a change.

GUESTS- Children and guests are encouraged to remain in the lobby, however, if there is a concern about the patient, please speak with our therapist. Please understand this policy is in place purely for the **safety** of your children or to decrease the traffic in the clinic. An adult in the waiting area must quietly supervise small children.

I have read and understood the above. I understand that attendance at each therapy session is important to my recovery and will notify my therapist if unable to attend a session so that it may be rescheduled.

Patient signature: _______________________________________ Date: ______/____/______

Parent Signature: _______________________________________ Date: ______/____/______
(If Minor)

Thank you in advance for you understanding and cooperation. We look forward to participating in your rehabilitation.

PEAK MOTION
PHYSICAL THERAPY

TREATMENT POLICY

❖ PAYMENT POLICY AND BILLING PROCEDURES

1. **You are responsible for the co-pay, co-insurance and/or deductible not covered by your insurance company. Payment is required at the time of each visit. Peak Motion will** NOT **bill you for co-pays, co-insurance, and deductible.**
2. **Your** estimated **co-pay amount is $____________per visits. Your** estimated **coinsurance amount is$____________ per visit. Your** estimated **deductible amount is $____________.Payment is due in full at the time of your visit.**
3. **You will receive a statement, which will show you the status of your account.**
4. **We accept Visa, MasterCard, and Discover bankcards.**
5. **There is a $40 charge for all returned checks.**

❖ INSURANCE INFORMATION

As a courtesy to our patients, we will call your insurance company for benefit information, and we will file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. **Many insurance companies have stipulations that limit the benefit in some way, such as sessions, supplies, deductibles, co-pays, etc. The stipulations should be noted in your policy manual.**

❖ SUPPLIES POLICY

SUPPLIES: Payment for all supplies not covered by insurance is due at the time of service.

MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible to pay for all supplies used for your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

WORKER'S COMPENSATION benefits will be reviewed; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

MEDICAL RECORDS: Medical records will be provided within 30 days after the date of your request. If you require Medical records prior to 30 days, you will be billed a **$40.00** convenience charge.

❖ CONSENT TO TREAT

I understand that I have been referred for rehabilitative treatment and care to Peak Motion Physical Therapy. Peak Motion will perform an Initial evaluation and then describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Peak Motion Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policies and billing procedures of Peak Motion Physical Therapy. I hereby authorize Peak motion Physical Therapy to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign Peak Motion Physical Therapy all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Outpatient Rehabilitation. It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Peak Motion Physical Therapy for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

❖ BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I,______________________________, authorize Peak Motion Physical Therapy, Inc., to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name:____ Relationship:_____________________________________

Name:____ Relationship:_____________________________________

❖ HIPAA: A copy of the Notice of Privacy Practices was provided to me by Peak Motion Physical Therapy, Inc. and I have read and understand the HIPAA Act. (Initials):_________

Print Name:____

Signature:____ Date: ____/____/____

PEAK MOTION PHYSICAL THERAPY, INC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE CLINIC, WHETHER MADE BY THE CLINIC OR A BUSINESS ASSOCIATE.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. From time to time, the Secretary of Health and Human Services may make changes in the rules and regulations regarding the use or disclosure of PHI. We will continue to update and modify our privacy practices to remain in compliance with such regulations. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a copy by calling the office and asking for one at the time of your next appointment or by requesting a revised copy be sent to you in the mail.

1. How We May Use and Disclose Medical Information About You.
Your Protected Health Information ("PHI") may be used and disclosed by your therapist, our office staff and others outside of our office involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to collect payment for your health care services and to support the operation of Peak Motion Physical Therapy. Following are examples of the types of uses and disclosures of your protected health care information that is permitted:

Treatment: We will use and disclose such portions of your PHI to provide, coordinate, or manage your health care and any related services. This may include the coordination or management of your health care with a third party, including your pharmacist. We will also disclose PHI to other providers who may be treating you or with whom we have consulted about your treatment. In addition, we may disclose your PHI to another therapist, physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities your health insurance plan may undertake before it approves or pays for the health care services we recommend for you and may include, but are not limited to, the following: making a determination of eligibility or coverage for insurance benefits; reviewing services provided to you for medical necessity; undertaking utilization review activities; reports to credit bureaus or collection agencies; and, to our attorneys for collection, if necessary.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of Peak Motion Physical Therapy. These activities include, but are not limited to, the following: quality assessment activities; employee review activities; health care or financial audits; training of therapy students; licensing and fundraising activities; and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to discuss your appointment. This contact will include leaving messages on your home answering machine or mailing notices to your home.

We will share your PHI with third party "business associates" who perform various activities (e.g., billing, transcription services) for the Clinic.

We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our Clinic and the services we offer. You may contact our Privacy Officer to request these materials not be sent to you.

We will take steps to reasonably secure your PHI in our custody and to have backup systems if PHI is kept in an electronic form. We will use our best efforts to secure your PHI, but cannot guarantee the information is secure from all risks or potential wrongdoers.

2. Uses and Disclosures of PHI Based Upon Your Written Authorization
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent your therapist or the Peak Motion Physical Therapy has taken an action in reliance on the use or disclosure indicated in the authorization.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization
We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your therapist may,

using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI relevant to your health care will be disclosed and only so much information that is minimally necessary under the circumstances.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI directly relating to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other responsible person of your care, your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens and you have not already been provided a copy, we will try to obtain your acknowledgment of receipt of the Peak Motion Physical Therapy Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

4. The Law Provides for Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include the following:

Required By Law: We may use or disclose your PHI to the extent the use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies overseeing the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority authorized by law to receive reports of child or senior citizen abuse or neglect. In addition, we may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing reviews, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event a crime occurs on the premises of the clinic, and (6) medical emergencies (not on the clinic's premises) where it is likely a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for organ or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your therapist created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Section 164.500 et seq.

5. Your Rights

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records your therapist and the Clinic use for making decisions about you. You will be charged a reasonable fee if you are requesting copies. If we keep your medical records in an electronic form, you may request copies of your records in an electronic form such as a CD or the like. You will be charged a reasonable fee for such copies similar to the charge as if paper copies were provided. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may ask us not to disclose a part of your medical information to others if you have paid in full for the services related to that treatment when we may otherwise have billed your insurance company or other persons for such medical services. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to all restrictions you may request other than the request not to disclose information for services for which you have already paid in full. If the therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your therapist does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your therapist.

We will not use or disclose your PHI for marketing purposes or sell any such information to other parties, except as expressly permitted by law.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your therapist amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You

have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. If we keep your PHI in electronic form, such as electronic health records, upon request, we will provide an accounting for all disclosures of PHI for any purpose beginning the latter of; 2011; after we implement electronic health record systems; or when regulations require such disclosure in the future. This does not apply if we do not keep PHI in an electronic form.

You have the right to be notified if an unauthorized disclosure has occurred. Under certain circumstances, if an unauthorized disclosure or use of your PHI has occurred, you have the right to receive a notice from us of the circumstances and the steps taken to correct the circumstances or to prevent it from occurring in the future. Under certain circumstances, you would have the right to ask us to destroy any PHI in our possession, subject to our rights to retain certain copies for the protection of the therapist.

You have the right to obtain a paper copy of this notice from us.

6. Complaints

You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer. We will not retaliate against you for filing a complaint. You may contact our Compliance Officer, for further information about the complaint process.

This notice was published and becomes effective on September 23, 2013.