PEAK MOTION
PHYSICAL THERAPY

PATIENT HEALTH HISTORY
CONSENT TO TREAT

Peak Motion will perform an Initial evaluation and then explain to 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.

Signature _____ **Date** _____

❖ *Patient Information*

Patient Name:_____ DOB: _____/_____/_____ Age _____

How did the injury occur_____ EMAIL: _____

Occupation:_____ Emergency Contact:_____

Emergency Phone #:_____

Referring Dr *or* PCP:_____ **Dr Office:** _____

❖ *Patient History*

Date Symptoms Began / Date of Injury:

_____/ _____/ _____

How long have you had this condition/pain?

_____Years _____Months _____Weeks

How did the symptoms/ pain start?

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

What activities reduce symptoms/pain?

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

Have you had any diagnostic tests?

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

Have you had surgery for this condition/injury?

Yes / No : _____

Other Surgery: _____

What activities increase symptoms/pain?

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

List your Medication:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Place a checkmark for ***YES***. Please indicate if ***NONE*** of these apply.

- ☐ (Ir)Regular Headaches
- ☐ Allergies: _____
- ☐ Arthritis (OA or RA)
- ☐ Behavioral Health
- ☐ Bowel/Bladder Issues
- ☐ Cancer: _____
- ☐ Cognitive/Developmental
- ☐ Diabetes
- ☐ Dizziness/Blackouts
- ☐ Heart Disease
- ☐ Hearing
- ☐ High Blood Pressure
- ☐ Physical Impairment(s)
- ☐ Pulmonary
- ☐ Seizures
- ☐ Stroke (CVA)
- ☐ Asthma/ Breathing Issues
- ☐ Heart Attack
- ☐ Hernia
- ☐ HIV/AIDS/Hep C
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Sexual Dysfunction
- ☐ Smoker
- ☐ Vision
- ☐ Metal Implants: _____
- ☐ Other: _____
- ☐ NONE OF THE ABOVE

Patient Signature:_____ Therapist Signature:_____

Body Chart

Date: _____/_____/_____

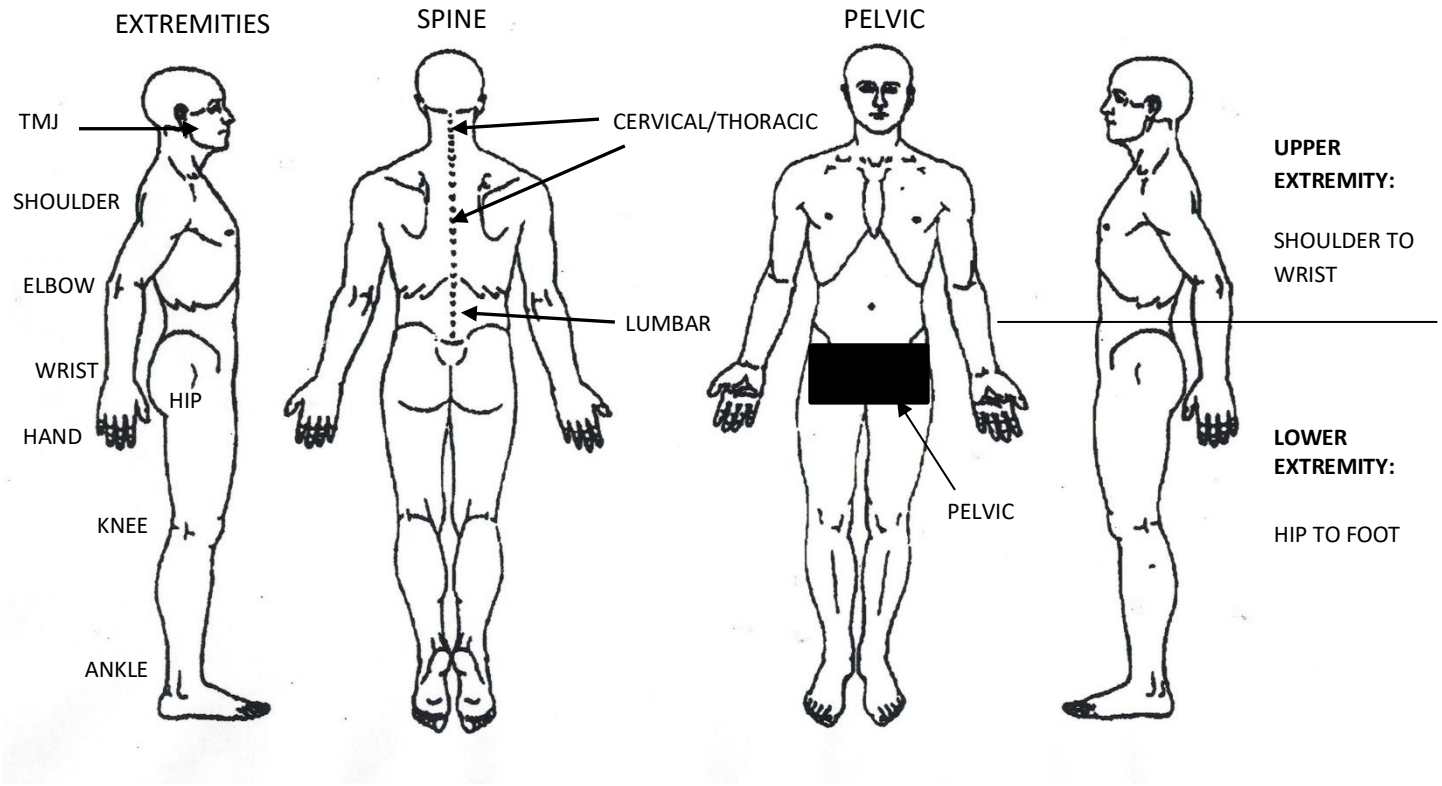
Patient Name:_____ Case Number: _____

Rate your Pain (0-10): _____

0=No Pain :: 10=Emergency Room Required

Mark on the chart where you are experiencing your symptoms:

LEFT :: RIGHT



- **Neuromuscular; this is usually associated with a diagnosis involving nerves and muscle:**
  Examples: Multiple Sclerosis (MS), ALS, Polio, Muscular Dystrophy (MD)

PEAK MOTION PHYSICAL THERAPY

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE - Insurance Company: _____

Policy Holder's Name and Employer: _____

Relationship to Policy Holder (PH): ( ) Self ( ) Other - DOB of PH: _____

Patient SSN: _____ Phone Number: _____

Patient Address: _____

SECONDARY INSURANCE - Insurance Company: _____

Policy Holder's Name and Employer: _____

Relationship to Policy Holder (PH): ( ) Self ( ) Other - 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 auto insurance? _____ If you are going through your personal health insurance, please notify front office staff before being seen.

*** PLEASE BE AWARE THAT WE DO NOT ACCEPT THIRD PARTY LIABILITY INSURANCE OR LITIGATION (LOP).**

❖ **DISCLOSURES OF PERSONAL HEALTH INFORMATION (MEDICAL RECORDS)**

MEDICAL RECORDS: Medical records will be provided within 10 days after the date of your request, and they are free to you. A $40 fee is charged to attorneys, insurance companies, etc.

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. & I have read and understand the HIPAA Act. (Initials):_____

Patient Name: _____

Signature of Patient or Guardian: _____ Date: _____/_____/_____

PEAK MOTION PHYSICAL THERAPY

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.**
- **Physical Therapy**: a **$25 no-show/late cancellation** charge will be applied to those who do not give 24 hours' notice.
- **Occupational Therapy and Pelvic Therapy**: a **$75 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.

PATIENT FINANCIAL RESPONSIBILITY

1. ASSIGNMENT OF BENEFITS: PMPT will send all claim(s) for payment to my insurance carrier for each visit(s) of treatment and payments from my insurance carrier will be applied to my account. I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. *Initial:* _____

2. I understand that it is my responsibility to call my insurance carrier to find out all information related to my outpatient physical therapy benefits, coverage, and what my financial responsibility for my treatment will be. *Initial:* _____

3. I understand that I will pay a co-payment, a co-insurance payment, or pay a deductible at each Peak Motion Physical Therapy (PMPT) treatment according to my plan coverage. *Initial:* _____

4. I understand that PMPT will send me a bill for the balance due on my account, until all claims are finalized and after PMPT have received payment(s) from my insurance carrier. I understand that the balance I owe to PMPT IS DUE UPON RECEIPT. *Initial:* _____

5. I understand that my PMPT statement may be delayed after my treatment has ended because of the time it takes the insurance companies to process insurance claims. *Initial:* _____

6. I understand that if I do not pay my balance in full, PMPT will turn my account balance over to an attorney/collection. I understand I will be liable for the balance owing on my PMPT account, plus the attorney/collection fees and cost. *Initial:* _____

I have placed my initials after reading and understanding each paragraph above, I agree with the above terms, and I understand the PMPT billing process. 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 Name (print): _____

Patient/Parent Signature: _____ Date: _____/_____/_____

PEAK MOTION PHYSICAL THERAPY

Patient Financial Responsibility Form

Thank you for choosing Peak Motion Physical Therapy. We are honored by your choice and are committed to providing you with quality physical therapy and rehabilitation care.

The medical services you seek imply a financial responsibility on your part. Please note that it is the responsibility of the patient/guardian to know their individual insurance benefits, please call your insurance carrier to understand your physical therapy coverage. As a courtesy, we will verify your insurance coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for all charges incurred and the payment of your account in full.

- Patient/guardian is required to provide the most accurate and updated information regarding insurance carrier. If there is a change of insurance, it is patient/guardians responsibility to notify Peak Motion immediately with all pertinent information.
- Patient/guardian is responsible for payment of copays, coinsurance, deductibles, and any charges incurred for procedures/treatments that are not covered by their insurance. These payments are due at the time of service. For your convenience we accept cash, checks, visa, master card, and discover.
- Any outstanding, past due account balances will be turned over to an attorney/ Collection agency. Charges incurred for cost of attorney/collection agency will be the responsibility of patient/guardian.
- There will be a $40 charge for all returned checks.
- Patient/guardian will incur a $25 no show/cancellation fee (unless 24 hours' notice is given).

I agree to pay, promptly and in full, any remaining balances on my account, including copayments, coinsurance, deductibles and all charges for services rendered that are not payable by my insurance. I understand that account balances not paid by my insurer within 90 days are my responsibility.

- I authorize Peak Motion personnel to communicate with me by mail, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration.

☐ I would like someone from the billing department to review my medical benefits with me.

☐ I do not wish to have the billing department review my medical benefits with me. _____ (initial).

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Patient Name: _____

Signature of Patient or Guardian: _____Date:_____