i

## PATIENT INFORMATION

**How did you hear about us?**
__ My doctor sent me
__ Television __ Newspaper
__ Radio __ Other _____

**Today's Date**: _____

**Date of Injury:** _____ **State Injury Occurred:** _____

**Patient's Name**: _____ **Referring Physician**: _____

**Address**: _____ **City/State**: _____ **Zip**: _____

**Hm ph**: _____ **Wk ph**: _____**Cell ph**: _____

**Marital status**: Single/Married/Separated/Divorced/Widowed **Sex**: M / F **D.O.B:** _____

**S S #.** _____ **Email Address**: _____

**Name of Employer:** _____

### RESPONSIBLE PARTY INFORMATION

**Name of parent/guardian**: _____**Relationship**: _____

**Address**: _____ **City/State**: _____ **Zip**: _____

**Hm ph**: _____ **Wk ph**: _____ **Cell ph**: _____

**Is the patient a minor?** (Under age 18) YES / NO If so, how old _____

Is this injury related to any of the following: WORK / CAR WRECK / SCHOOL ATHLETICS / OTHER?

_____ Has the patient received any type of **physical therapy / home health** services within the current calendar year? (for this injury or any other injury) YES / NO If yes, explain: _____

If the injured is a student provide name of school: _____

**METHOD OF PAYMENT** ( ) Health Insurance ( ) Workers Comp. ( ) Self Pay ( ) Attorney/Personal Injury ( ) Auto Insurance

Are you now, or planning to be, represented by an attorney in this matter? YES / NO If yes, please provide attorney's info:
**Attorney's Name**: _____ **Attorney Ph:** _____

### INSURANCE POLICY HOLDERS INFORMATION

**Name**: _____ **D.O.B**: _____ **S.S. #** _____

**Address**: (if different from patient) _____

**Name of employer:** _____ **Relationship to patient**: _____

### CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Peak Performance Physical Therapy to release information concerning my treatment, including the reproduction of my medical records, for each third party insurer from whom I may seek payment or reimbursement for expenses related to my treatment. I further assign all benefits and authorize payments directly to Peak Performance Physical Therapy for the insurance benefits to which I am entitled and which are otherwise payable to me, but not to exceed Peak Performance Physical Therapy's regular charges for services rendered during this period of treatment. I understand, unless otherwise specifically provided by contract that I am and remain financially responsible to Peak Performance Physical Therapy until my account is paid in full, whether or not covered by this authorization.

### CONSENT FOR TREATMENT

I, _____, hereby allow Peak Performance Physical Therapy to render treatment to me based upon my specific complaints and the referral from my physician. I understand that my treatment from Peak Performance Physical Therapy is based upon findings from my medical doctor and release Peak Performance from responsibility for resulting illness, ill effect, or reaction from treatment ordered by my physician.

**I have read all of the above and certify that I understand its content.**

**Signature of Patient** (or parent if patient is a minor) _____ **Date:**_____

# Current Medical Condition

Patient Name: _____

How were you injured? _____

Date of injury/onset: _____ Date of surgery? _____

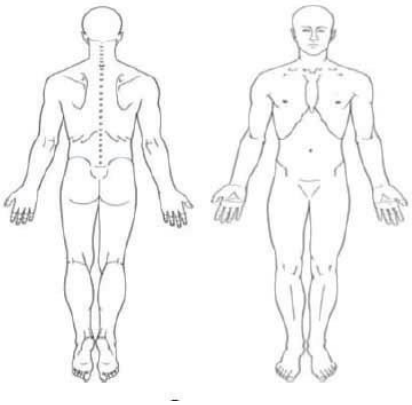
Body part injured: _____

Have you received physical therapy treatment this year? YES NO If yes, when? _____

Have you fallen recently? YES NO If yes, how many times this year and were you injured during the fall? _____ _

## Patient Pain Assessment

Indicate where your pain is located using the pictures below



How often do you experience your symptoms?

a. Constantly (76-100% of the day)
b. Frequently (51-75% of the day)
c. Occasionally (26-50% of the day)
d. Intermittently (0-25% of the day)

What best describes the nature of your symptoms?

a. Sharp
b. Dull ache
c. Numb
d. Shooting
e. Burning
f. Tingling

How are your symptoms changing?

a. Getting Better
b. Not Changing
c. Getting Worse

What makes your symptoms better? (Ex. Rest, medication) _____
_____

What makes your symptoms worse? (Ex. Lifting, sitting, bending, stairs, squatting, kneeling) _____
_____

## Pain Scale

Please use the number scale to rate your pain level

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**CURRENT** pain level _____ Pain at its **WORST** _____ Pain at its **BEST** _____

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

## Patient Medical History

Patient Name _____ Date _____

Referring Physician _____ Family Physician _____

Age _____ Height _____ Weight _____

### PLEASE SELECT YES OR NO TO ALL PAST MEDICAL CONDITIONS

| MEDICAL CONDITIONS | YES | NO | DATE OF ONSET/COMMENTS |
|---|---|---|---|
| Allergies (type) | | | |
| Anemia | | | |
| Arthritis (type and location) | | | |
| Back Injury/Surgery | | | |
| Blood Clot | | | |
| Bowel Control/Bladder Leakage/Urgency | | | |
| Broken Bones (list) | | | |
| Cancer or Chemotherapy/Radiation | | | |
| Chest Pain/Angina | | | |
| Coronary Heart Disease | | | |
| Diabetes (type) | | | |
| Difficulty Sleeping | | | |
| Dizziness/Vertigo | | | |
| Elbow/Hand Injury or Surgery | | | |
| Fainting | | | |
| Fibromyalgia | | | |
| Fractures (list) | | | |
| Headaches (how often) | | | |
| Heartburn | | | |
| Heart Attack/Surgery | | | |
| Hernia | | | |
| High Blood Pressure | | | |
| Hip Injury/Surgery | | | |
| History of Falling | | | |
| Increased Pain at Night | | | |
| Infectious Disease (Hepatitis/HIV) | | | |
| Joint Replacement (location) | | | |
| Kidney/Urinary Tract Disease | | | |
| Knee Injury/Surgery | | | |
| Leg Injury/Surgery | | | |
| Lung Disease | | | |
| Nausea/Vomiting | | | |
| Neck Injury/Surgery | | | |

| | | | |
|---|---|---|---|
| Numbness/Tingling (location) | | | |
| Osteoarthritis (location) | | | |
| Osteoporosis | | | |
| Pacemaker | | | |
| Pins/Metal Implants (location) | | | |
| Pregnant (trimester) | | | |
| Recent Procedures/Injections | | | |
| Respiratory Problems | | | |
| Restrictions with Walking/Exercising | | | |
| Seizures (type) | | | |
| Shoulder Injury/Surgery | | | |
| Shortness of Breath | | | |
| Skin Conditions (type/location) | | | |
| Smoke | | | |
| Stroke/TIA | | | |
| Tumors | | | |
| Vision or Hearing Problems | | | |
| Weakness | | | |
| Weight Loss | | | |

Please list any other medical conditions that you may have/had that is not listed above:

_____

_____

_____

_____

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

# Medication List

Patient Name _____ Date _____

Please list all prescription drugs and/or non-prescription medications; including vitamins, nutritional supplements, etc.

| NAME OF MEDICATION | DOSAGE (HOW MUCH) | FREQUENCY (HOW OFTEN) | DELIVERY (HOW IS IT TAKEN) | WHY (REASON FOR TAKING) |
|---|---|---|---|---|
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Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Rev 2/16

Our Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment. Please let us know if you have any questions or concerns. Our office staff will be happy to provide you with more information regarding payment options.

PAYMENT OPTIONS

Payment of co-pays and/or any unmet deductible is due at time of service. If you have a large deductible we can work a payment plan out for you. We accept cash, checks, or most major credit cards.

***Regarding Insurance***

We do accept assignment of insurance benefits and will be happy to file claims on your behalf. The balance is your responsibility regardless of whether your insurance company pays or not. We cannot bill your insurance company unless you give us your COMPLETE AND CURRENT insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to ensure they live up to the terms of that contract. If the insurance company requests information from you, it is your responsibility to send it to them. If it is not received, your claims will be denied and you will be responsible for the amount of your bill. If the insurance company has not made full payment within 120 days we will bill you the entire amount that is owed. If you prefer to file insurance claims yourself, you may pay your account in full using the above methods. We will assist you by providing all appropriate information your insurance company will require.

Please be aware that some of the services provided may not be considered necessary under the terms of your particular plan. Please be assured that our practice will provide only those services which your doctor and physical therapist determine are necessary for you.

PATIENT PAYMENT GUARANTEE

Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area. Please remember that you are responsible for all charges and expenses of Peak Performance Physical Therapy, of every kind and description, for services, facilities and any other thing supplied or furnished the patient. If the account goes to our outside collection agency, the patient agrees to pay any additional costs in obtaining the amount due.

I (Print Name) _____, have read and understand the above financial policy and agree to abide by this policy.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

# Non-Covered Items

Due to the fact that many insurance companies are disallowing certain items from their coverage plans, there may be some supplies which your therapist will use, or recommend, which are not covered by insurance reimbursement. One example of this is the set of electrode pads used with electrical stimulation. If electrical stimulation is used in your treatment plan, a new, unopened, re-usable set of electrode pads will be needed. Upon receipt of the pads, you the patient will be responsible for paying the one-time charge of $10.00 for these pads.

Examples of some other items which are sometimes recommended are; Theraband Exercise Bands, Biofreeze, braces and supports, home traction units, TENS units, etc…

If any of these items are required, you will be notified prior to use so that you are aware of any potential out of pocket expenses you will be responsible for.

Thank you and please let us know if you have any questions…

Patient Signature: _____ Today's Date: _____

Print Patient Name: _____

Peak Employee: _____ Today's Date: _____


11320 Industriplex Blvd.
Baton Rouge, La 70809-4108
Ph# 225-295-8183
Fx# 225-295-8236

145 Aspen Square, Ste A
Denham Springs, La 70726-5304
Ph# 225-667-8989
Fx# 225-667-9554

3103 Monterrey Blvd, Ste A
Baton Rouge, La 70814-4024
Ph# 225-924-1088
Fx# 225-924-4717

7069 Perkins Rd
Baton Rouge, La 70808
Ph# 225-769-6161
Fx# 225-769-7661

36491 Dutchtown Gardens Ave.
Geismar, La 70734-3081
Ph# 225-744-7325 (PEAK)
Fx# 225-744-7330

4463 Hwy 1 South, Ste B
Port Allen, La 70767-5907
Ph# 225-749-8980
Fx# 225-749-9096

Financial Resources Dept.
6756 Langley Dr. Ste A
Ph# 225-663-8232
Fx# 225-246-8730

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## NOTICE OF PRIVACY PRACTICE PURSUANT TO 45 C.F.R. 164.520

### Our Duties

We are required by law to maintain the privacy of your Protected Health Information. We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our "Notice of Privacy Practice" currently in effect. However, we reserve the right to change our privacy practices in regard to Protected Health Information and make new privacy policies effective regarding all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our privacy officer, at our correct address.

### Your Complaints

You may complain to us and to the Secretary of The Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to our privacy officer at our current address, stating what Protected Health Information you believe has been used or disclosed improperly.You will not be retaliated against for making a complaint. For further information you may contact our privacy officer at (225) 295-8183.

### Description and Examples of Uses and Disclosures of Protected Health Information

Some examples of how we may use or disclose your Protected Health Information are as follows. In connection with treatment we will allow a physician associated with us to use your medical history, symptoms, injuries, or diseases to treat you. We may also disclose your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain a payment for the services we rendered on your behalf. In connection with health care operations, we may allow our auditors, consultants, or attorneys access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

### Usage and Disclosures Not Requiring Your Written Authorization

The privacy regulation gives us the right to use and disclose your Protected Health Information if: (1)You are an inmate in a correctional institution, (2)We have a direct or indirect treatment relationship with you, (3)We are so required to by law. The purpose for which we may use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those decribed above. Several of our clinics are located in health clubs which may allow you to be seen by other individuals who are not patients while receiving some forms of treatment. If requested, we will make every effort to provide as much of your treatment as possible in a private room.

### Usage of Protected Health Information to Contact You

We may use your Procteted Health Information to contact you regarding appoinments, reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

**Disclosures of Protected Health Information for Billing Purposes**

We may disclose your billing information to any person that calls our billing agents with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan policy number.

**Disclosures for Directory and Notification Purposes**

If you are incapacitated or not present at the time of disclosure we may diclose your Protected Health Information (a)for the use in a facility directory, (b)to notify family or other appropriate persons of your location or condition and to inform family, friends, or caregivers of information relevant to their involvement in your care or payment for your treatment. If you are present and not incapacitated at time of disclosure, we will share the above disclosures only upon your signed consent, verbal agreement, or the reasonable belief that you would not object to disclosures.

**Individual Rights**

You may request us to restrict the uses and disclosures of your Protected Health Information, but we do not have to agree to your request. You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or pursuant to an alternative means (i.e. a sealed envelope rather than a post card, a specific phone number, sending mail to a specific address etc.). We are required to accommodate all reasonable requests in this regard. You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and cost to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected and copied. Thus, each request will be reviewed in accordance with the provisions published in 45 C.F.R. 164.524. You have the right to amend your Protected Health Information, as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, is not a part of the designated record set, would not not be available for inspection as described under 45 C.F.R. 164.524, or if the Protected Health Information is already accurate and complete without regard to the ammendment. We have the information for six years after the date upon which you request the accounting. An exception to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each Request for an accounting will be reviewed pursuant to the rules of section 164.528. You also have a right to receive a copy of this notice upon request.

The Effective Date of this notice is April 14, 2003

I hereby acknowledge that I have received a copy of this notice.

Patient Signature_____

Date_____