



161 East Commercial Street
East Rochester, NY 14445
Phone: 585.218.0240 - Fax: 585.218.0245

Patient Acknowledgement & Release Form

Patient Name: _____

- New Patient to this facility
 Change in insurance coverage

Person responsible for payment: _____
(if different than patient).

- Is this injury the result of M.V.A. or work?
 M.V.A. (Motor Vehicle Accident) Work Neither

Injury/Diagnosis: _____

WHAT HELPED YOU CHOOSE PEAK PERFORMANCE PT? (Please check all that apply)

- I'm a Former Patient Referred by Friend/Family Location Website Info I Know PT/Staff Newsletter
 Online Search Found in Phonebook Referred by Doctor _____ Other _____

INSURANCE TYPE (if more than one type, indicate primary and secondary)

- Aetna Blue Choice BC/BS Cigna Family Health/Child Health Self Pay MVP Medicare
 No-Fault United Health Care Workers Compensation Other _____

I've had _____ PT _____ OT _____ Speech visits already this year (same/different body part?)

The following is a good-faith *estimate* of insurance coverage for physical therapy services. It is your responsibility to verify your insurance coverage and eligibility requirements of your particular insurance plan.

- 100% coverage _____% ins. coverage, _____% patient responsibility
 \$_____ co-payment per visit \$_____ deductible, \$_____ remaining
 No coverage \$_____ *estimated* co-insurance per visit
 Other/Comments: _____

FINANCIAL ACKNOWLEDGEMENT

I, the undersigned:

- Agree that I am financially responsible for all services rendered to me (or to the patient, if different) by Peak Performance PT;
- Agree that I am personally responsible for all co-payments, deductibles, and any non-covered services or items (such as electric stim pads, tubing, iontophoresis pads) for the insurances for which *Peak Performance Physical Therapy* accepts assignment;
- Agree to pay a \$20 fee to Peak Performance PT for any returned check (in addition to any fees my bank may charge me);
- **Agree to pay \$30 per instance, prior to any subsequent treatments, for no-shows and same day cancellations.**
- Understand the importance of attending my PT sessions on time and as scheduled and that no-show and cancelled visits may prevent other patients from scheduling in that slot to obtain their needed care. I will make every possible effort to attend visits as scheduled, call in a timely manner to reschedule visits should a problem arise, and give 24 hr notice whenever possible should I have to cancel a visit;
- Agree to pay all attorney's fees/collection costs to the extent allowed by law for any delinquent account balance;
- Authorize payment of medical insurance benefits directly to Peak Performance Physical Therapy;

Signed _____ Date _____

RELEASE OF INFORMATION

I hereby authorize the referring and/or primary care physician, insurance carrier, or the carrier's specified agent/representative to receive the necessary information pertaining to my treatment as requested to expedite claim payment and/or further authorization for treatment

Signed _____ Date _____

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I am familiar with the HIPAA of 1996 document. I am aware that Peak Performance Physical Therapy will abide by the HIPAA guidelines with regard to the privacy of my personal health information. HIPAA document is available upon request.

Signed _____ Date _____

Past Medical History & Subjective Questionnaire

NAME: _____

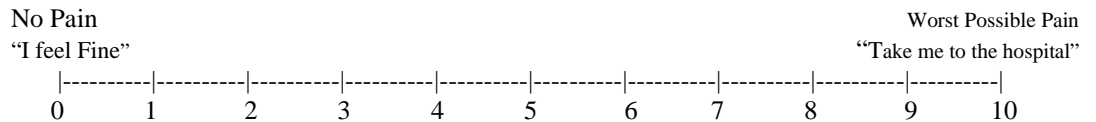
DATE: _____

USE THE SYMBOLS BELOW TO MARK THE AREA(S) ON THE BODY DIAGRAM WHERE YOU HAVE SYMPTOMS:



- “P” = Pain
- “N” = Numbness
- “B” = Burning
- “A” = Ache
- “T” = Tingling / Pins & Needles
- “S” = Stabbing
- “I” = Instability / Giving Way

Please use the scale below to indicate the worst intensity of pain you have had in the past week:



DO YOU CURRENTLY, OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes.....			Shortness of Breath/Asthma.....		
High Blood Pressure.....			Dizziness.....		
Heart Disease.....			Neurologic Disorder.....		
Heart Attack.....			Psychological Treatment.....		
Stroke.....			Cancer.....		
Pacemaker.....			Kidney Problems.....		
Seizures.....			Are you pregnant?.....		
Prior Surgery.....			Allergies Heat/Ice/Latex/Adhesive..		
Headaches.....			Hernia.....		
Infectious Disease.....			Metal Implant.....		

If yes, please explain and give approximate dates: _____

Are you presently taking any medications or supplements? Yes/No (please circle) If yes, please list: _____

Please list any past orthopedic injuries or surgeries you have had: _____

I am currently being treated by a (circle all that apply) Doctor, Osteopath, Chiropractor, Massage Therapist, PT for: _____

The problem I am coming to Physical Therapy for: (please circle) Developed Gradually/Sudden Injury Date of Onset: _____

My symptoms are: Constant (all day long regardless of position or activity) OR Intermittent (change with activity or position)

My problem includes: Giving Way/Buckling “Locking” (must shake body part to free up motion) Pain / Ache / Soreness
(circle all that apply)

“Catching” (gets “hung up” or “stuck” but not truly locked) Weakness/Inability to perform life-work-sport

Things that worsen my symptoms: _____

Things that reduce my symptoms: _____