PEAK PERFORMANCE Physical Therapy
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).

Injury/Diagnosis: _____

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

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
☐ $_____ co-payment per visit
☐ No coverage
☐ Other/Comments: _____

☐ _____% ins. coverage, _____% patient responsibility
☐ $_____ deductible, $_____ remaining
☐ $_____ *estimated* co-insurance per visit

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;
- Have received a copy of the "Fee Schedule and Billing Policies" brochure (if requested) and agree to abide by the policies contained therein.

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_____

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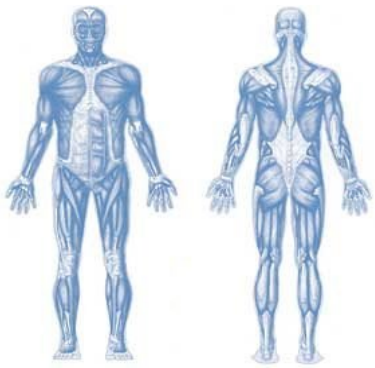
Past Medical History & Subjective Questionnaire

NAME:_____ DATE:_____



USE THIS KEY TO LABEL THE ADJACENT BODY DIAGRAM

Pain: P P
Ache: ^ ^
Numbness: = =
Burning: x x
Pins & Needles: O O
Stabbing: / /
Giving Way/Instability: S S

Mark the area(s) on the body diagram where you feel any of the above sensations, making sure to use the correct symbol. Please include all affected areas.

Please use this scale to indicate the worst intensity of pain you have had recently:

|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|

No Pain… "I feel Fine"

Worst Possible Pain…"Take me to the hospital"

DO YOU, 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: _____

_____

The problem I am coming to Physical Therapy for: Developed Gradually/Sudden Injury(circle) 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 wiggle or shake body part to free up motion)
(please circle)
"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:_____