PEAK PERFORMANCE
PHYSICAL THERAPY & SPORTS MEDICINE

One Home for all Your Rehab Needs

1940 Harve Ave | Missoula, MT 59801
(406) 542-0808 | Fax: (406) 542-0909

Consent and Conditions for Treatment

Last Name:_____ First:_____ DOB:_____

Conditions, Uses and Disclosures

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. You have the right to restrict disclosure of your health info, the right to inspect and copy your health information, the right to submit corrections; you may request a copy of this notice. We reserve the right to amend or modify our privacy practices as they may be federally required.

Treatment: Your health information may be used and shared by staff members and your healthcare providers for continuation of care. Your health records may be disclosed to other health care professionals (with your authorization on our medical records release form) for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. Peak Performance PT,PC originates and maintains health records for describing their health history, symptoms, examination, test results, diagnosis, treatment, and plans for future care and treatment. The health records will be retained by Peak Performance PT,PC for seven years.

Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage such as an auto insurer, or credit card companies that may pay for services. For example, your health plan may request and receive information on dates of service, services provided, and medical condition being treated.

Health Care Options: Your health information may be used as necessary to support the day to day activities and management of Peak Performance PT,PC. For example, information on services provided may be used to support budgeting and financial reporting activities and to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report communicable diseases to the state's public health department.

Additional Uses: Other disclosures for any purpose require your specific written authorization.

Patient Responsibilities:

- It is the patient's responsibility to ensure that if their insurance requires a referral for treatment that a referral is provided to the practice **before the first visit.** Visits may be rescheduled or the patient may be financially responsible due to lack of referral.
- It is the patient's responsibility to provide Peak Performance PT,PC with current insurance information, to bring their insurance card, and to notify the office of any changes in insurance. Failure to do so may result in claim denials in which the patient/guarantor may be financially responsible.
- It is the patient's responsibility to check with their insurance regarding pre-authorizations, benefits, coverage (including whether or not Peak Performance is in or out of network), exclusions, and the allowed number of visits for physical therapy.
- It is the patient's responsibility to notify Peak Performance PT,PC in advance of a missed appointment. Appointments missed three times in a row or frequent cancellations may result in discontinuation of further appointments.

**As a courtesy to the patient, Peak Performance PT,PC will attempt to authorize, verify insurance benefits, and bill for claims. Remember that this is an outline of benefits, not a guarantee of payment by the insurance company; ultimately it is the responsibility of the patient/guarantor to ensure payment for services rendered.*

FOR MINOR PATIENTS ONLY: As the party responsible for medical decision-making for the child represented in this medical record, I hereby give my consent to Peak Performance PTPC to render both emergency and non-emergency healthcare services both in and out of my physical presence.

- I attest that I have read and understand the above: Yes Initials:_____

I attest to the fact that this is NOT a workers' comp, motor vehicle claim, or third party claim. If the insurance I supplied does not pay, I acknowledge that I am liable to pay in full for all services received. (If services are due to work comp, motor vehicle accident or third party claim, please skip this section.)

- Yes Initials:_____

By signing below, you acknowledge that you have read, understand, and agree with the above.

Signature of Patient/Legal Guardian:_____Print Name:_____

Relationship:_____ Date:_____

Breast Prosthesis / Mastectomy Bra Customer Information

Name:_____ DOB:_____ Age:_____ Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Referring Physician:_____

Employment Information: Retired ☐ Not employed ☐ Full time ☐ Part time ☐ Type of job:_____

Handedness: Right / Left Recreation / hobbies:_____

How did you hear about us? Radio Ads ☐ Newspaper Ads ☐ Website ☐ Facebook ☐ Mailings ☐ Yellowpages ☐

Word of mouth: if so, who can we thank:_____ Other:_____

History of Current Condition

Diagnosis:_____ Type of Breast Cancer:_____

Date of Diagnosis:_____ Date of Surgery:_____ Side Affected: R/L/Both_____

Type of Procedure (circle all that apply): Lumpectomy Mastectomy Sentinel Node Biopsy Axillary Node Dissection

Have you had, or will you have breast reconstruction (please describe):_____

Radiation Therapy Dates:_____ Chemotherapy: Dates/Type_____

Have you received physical therapy to address pot-operative pain, stiffness, and weakness? Yes ☐ No ☐

Please rate the amount of LYMPHEDEMA EDUCATION you have received: None Minimal Moderate Extensive

Have you had issues with lymphedema? Yes ☐ No ☐ Have you received PT for lymphedema? Yes ☐ No☐

Do you wear a compression sleeve? Yes ☐ No ☐ If yes (please circle): All the time Occasionally When flying

Do you feel a change in your arm / shoulder strength? Yes ☐ No ☐ Has your posture changed? Yes ☐ No ☐

Has your balance changed? Yes ☐ No ☐ Has your arm / shoulder range of motion changed? Yes ☐ No☐

Have you noticed a sensation of “fullness” in your arm, shoulder, chest, trunk or back? Yes ☐ No ☐

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I, _____, _____ / _____ / _____, _____
(Name of Patient) (Date of Birth) (Phone Number)

_____
(Street Address) (City) (State) (Zip)

Authorize my records to be released from: _____
(Name of oncologist, surgeon, and any other provider related to current post-mastectomy care.)

_____
(Street Address) (City) (State) (Zip)

My records to be released to: Peak Performance Physical Therapy .

1940 Harve Ave Ste 2 Missoula MT 59802
(Street Address) (City) (State) (Zip)

Type of Information to be disclosed:

Records concerning breast cancer surgery or current status of post-mastectomy condition to justify insurance billing for prostheses and/or bras.

The purpose of this disclosure is (check one):

____Medical Care _X_Payment of Claims/Benefits ____Personal Use
____Legal Investigation ____Insurance Application
____I have a claim for **Worker' Compensation** and I specifically authorize you to engage in verbal communications with the Workers' Compensation insurer about my protected health information.
____Other (please specify):_____

Permission to Release Record(s)

I understand that I may revoke this authorization by written notification at any time following this date, except for the information that may have been released prior to the revocation. This consent is valid for the limiting period as set by the Medicare Recovery Audit Contractors, which is currently three years. This authorization will be effective for all medical record(s) related to breast cancer surgery or current status of mastectomy condition.

I understand that in accordance with state and federal confidentiality regulation, the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, development disability, or psychiatric care only if I indicate above with my initials or signature. Further disclosure of this information without written consent is prohibited by law.

_____
(Signature of person giving consent) (Date)

The signature is of the: ____Patient ____Parent of Minor ____Legal Guardian
____Patient's Executor or Next of Kin
____Parson Authorized by Patient (specify relationship / authority)_____