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:_____

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Musculoskeletal Pain Condition

Name: _____ Date: _____

What are we treating you for? _____ When did it start? _____

How did it happen? _____

Has anything helped? _____ What makes it worse? _____

Surgery for this issue? Type: _____ Date: _____ Precautions: _____

History of previous injuries to this area: _____

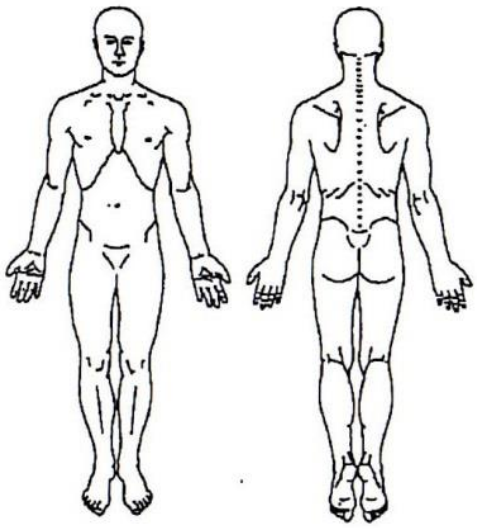
Rate your pain (0-10) Now _____ Worst _____ Best _____

Rate your ability to do things (1-100%) _____ Recreational & sports activities? _____

In general, are you: Getting worse □ Staying the same □ Improving □

Have you noticed any recent changes in: Bowel/bladder function □ Weakness □ Numbness □

Current work status: Not working □ Regular work □ Second job □ Modified work/limitations □



Please mark your pain/discomfort symptoms on the diagram:

A: Ache

S: Stabbing

R: Radiating

P: Pins and Needles

N: Numbness

O: Other

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New Patient General Medical Intake

Patient First Name:_____ Last:_____ MI:_____ Male ☐ Female ☐

Date of Birth:_____ Home Phone:_____ SSN:_____

Other Phone:_____ Email:_____

May we leave messages regarding appointment information on your voicemail? Yes ☐ No ☐

*Appointment Reminders: I understand that within the reminder, the location, date and time of my appointment will be provided. **Initials**_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employed? Yes ☐ No ☐ Place of work:_____ Contact Phone:_____

Guarantor/Responsible Party Name:_____ Male ☐ Female ☐

Date of Birth:_____ Home Phone:_____ SSN:_____

Other Phone:_____ Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Employed? Yes ☐ No ☐ Place of work:_____ Contact Phone:_____

Emergency Contact:_____ Phone:_____

Relationship to patient:_____

Additional individuals Peak Performance is authorized to discuss Protected Health Information (PHI) with?

Name:_____ Phone:_____ Relation:_____

Please select: Visit/Appointment Info ☐ Billing/Payment Info☐ Other_____

Name:_____ Phone:_____ Relation:_____

Please select: Visit/Appointment Info ☐ Billing/Payment Info☐ Other_____

Referring Provider (e.g. Doctor, Chiropractor, PA-C)_____

Whom can we thank for telling you about us? _____

Handedness: Right ☐ Left ☐

In general, my health is: Poor ☐ Fair ☐ Good ☐ Excellent ☐

In general, my fitness level is: Poor ☐ Fair ☐ Good ☐ Excellent ☐

Describe type/amount of exercise per week:_____

Recreation:_____ Hobbies:_____

Goals:_____

Social History:

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partnered ☐ # of Children:____

Smoking amount/day:_____ Tobacco: Yes ☐ No ☐ Marijuana amount/day:_____ Alcoholic drinks/wk:_____

Alcoholism: Yes ☐ No ☐ Chemical Addiction: Yes ☐ No ☐ Addiction Treatment: Yes ☐ No ☐

Living Environment:

Private home ☐ Private apartment ☐ Rented Room ☐ Assisted living/group home ☐

Homeless ☐ Long-term care/Nursing home ☐ Hospice ☐ Other:_____

Safety:

Stairs to navigate in living environment: Yes ☐ No ☐

Use of assistive device for ambulation: Cane ☐ Walker ☐ Manual wheelchair ☐ Motorized wheelchair ☐

Number of falls in the last 6 months:_____ Number of falls in the last 2 years:_____ Were you injured: Yes ☐ No ☐

Did you receive treatment for this injury? Describe:_____

Other Health Services receiving for the same problem:

Physical Therapy: ☐ Chiropractor: ☐ Acupuncture: ☐ Massage Therapy: ☐ Injections: ☐

If yes, please describe:_____

_____

Frequency and Duration (visits per week etc.):_____ Were they helpful: Yes ☐ No ☐

Surgical History:

Medications (please list all, or provide a list):

Test results for the issue that you are being treated for: (please list results of Labs, X-Ray, MRI, CT scan, DEXA, Arthrogram, etc.)

Medical and Surgical History Form

Do you have any of the following conditions as part of your **Past Medical History?** (unrelated to your reason for seeking physical therapy)

**please check all that apply*

□ Alzheimer's - or - Dementia
□ Cardiovascular Disease (such as chest pain, CHF, COPD, irregular heartbeat, pacemaker, fainting)
□ Cauda Equina Syndrome
□ Cerebral Vascular Accident (Stroke)
□ Current Infection
□ Diabetes Mellitus - Type 1
□ Diabetes Mellitus - Type 2
□ Fibromyalgia
□ Fracture -or- Suspected Fracture
□ High Blood Pressure
□ History of Cancer - please specify_____
□ Huntington's Disease
□ Immunosuppression
□ Lupus
□ Muscular Dystrophy
□ Obesity
□ Osteoarthritis
□ Parkinson's
□ Rheumatoid Arthritis
□ Traumatic Brain Injury

Other Conditions:

□ Allergies (bee stings, environmental, food, latex)
□ Anxiety, Depression, Mood Disorder
□ Blood Disorder (easy bruising, anemia, hepatitis, HIV/AIDS
□ Breast Health Disorder (rashes, discharge, lump, dimpling)
□ Changes in Constitution (fever, fatigue, weakness, appetite changes, unexplained weight loss/gain, change in bowel
□ Dizziness: __spinning __ rocking __ off balance
□ Gastrointestinal (eating disorder, difficulty swallowing, nausea, vomiting, stomach pain, diarrhea, constipation, peptic ulcer)
□ Headache (migraine, tension, cluster, other)
□ High Cholesterol
□ Inflammatory Bowel - or - Ulcerative Colitis - or - Chrohn's
□ Lymph Disorder (swollen lymph nodes, feeling of heaviness in arms/legs, swollen arm/leg/hand/foot)
□ Osteoporosis or Osteopenia
□ Psoriasis
□ Respiratory Disorders (cough, shortness of breath, wheezing, emphysema)
□ Sleep Disorders (apnea, insomnia)
□ Thyroid Disease
□ Urinary Disorders (painful urination, frequency or urgency, incontinence, pelvic pain, kidney disease)
□ Vascular Disorders (pain in legs while walking, foot/leg sores/ulcers, pain in legs while resting)

Females: Are you currently Pregnant? ___ Yes ___ No

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Motor Vehicle Questionnaire

This form must be completed and confirmed by adjustor before scheduling can occur.

Is this a third party claim?(Please circle one) YES NO

If yes, we will need also need the patients' auto insurance information with claim # and adjustor information.

Name of Patient:_____

Date of Birth: _____

Patient Phone Number:_____

Date of Accident:_____

State the accident was in:_____

Claim #:_____

Insurance Company Name:_____

Adjustor Name:_____

Adjustor Phone:_____ Adjustor Fax:_____

Claims Mailing Address:_____

_____

Claims Fax (if different than Adjustor Fax):_____

Is the claim open and billable?(Please circle) YES NO

Is the Insurance Company listed above accepting responsibility?(Please circle) YES NO

Is there a cap on benefits?(Please circle) YES NO

If yes, what is the cap amount?_____

Is there an Attorney involved? (Please circle one): YES NO

Attorney's Name:_____

Attorney's Phone Number:_____

Once Adjustor (and Attorney if acquired) has confirmed information provided above is correct, patient can be scheduled.

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Dear Patient,

Thank you for choosing Peak Performance Physical Therapy. Our policy regarding motor vehicle claims is that we can only carry $1,000 on your account at any one time.

If we are billing third party, we should also have your auto insurance information.

At no time will we be able to bill your private healthcare insurance.

Peak Performance Physical Therapy will bill after each visit so that they will receive the claim in a timely manner.

You will be notified if we are approaching the $1,000.00.

Ultimately you are responsible for payments of bills incurred.

If at any time you hire an attorney, we must be notified immediately so a lien can be sent.

If you will be self-submitting claims, please initial here to acknowledge that you are responsible for the services rendered at time of visit. **Initials:**_____

Please do not hesitate to contact us with any questions you may have regarding our policy. Again, thank you for choosing Peak Performance Physical Therapy for your rehab needs.

Patient Signature: _____ Date: _____

Print Name: _____

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Lien for Physical Therapy Services

TO:_____

_____

_____
(Insurance Company/Attorney)

RE:_____ Claim#:_____
(Patient Name)

NOTICE OF LIEN:

You are hereby given that Peak Performance Physical Therapy claims a lien for services rendered to

_____ From _____ To _____TBD_____
(Patient Name) (First Date of Service)

That total the amount being $_____TBD_____

The nature of the services rendered and an itemized statement showing the value of such services is submitted herewith and incorporated by references.

This lien is claimed pursuant to the ***Physician, Nurse, and Physical Therapist…Lien Act, 71-3-1111 to 71-3-1118 MCA.*** This act provides that "If any insurer or person, service, or death and the amount of the lien ***claimed by any physician, nurse, or physical therapist…has not been paid***, the insurer or person is liable to the physician, nurse or physical therapist.. for the reasonable value of the services. (71-3-1117, MCA)
Dated this _____ Day of _____ of _____
(Day) (Month) (Year)

Sincerely,

Peak Performance Physical Therapy

Employee Sign_____ Date _____