PEAK PERFORMANCE
PHYSICAL THERAPY & SPORTS MEDICINE
www.peakptmt.com ♦ 406-542-0808

CONSENT AND CONDITIONS FOR TREATMENT

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 records may be disclosed to other healthcare professionals (with your authorization on our medical records release form) for the purpose of evaluating your health, diagnosing and providing treatment. Peak Performance PT, PC maintains health records for describing your health history, symptoms, examination, test results, diagnosis, treatment, and plans for future care and treatment. These records will be retained 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 conditions being treated.
HEALTH CARE OPTION: Your health information may be used 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, financial reporting and to evaluate/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.

PATIENT RESPONSIBILITIES:

- Check with their insurance regarding referral requirements, 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. If referral is required, it must be provided to the practice before the first visit. Failure to do so may result in the patient being financially responsible.
- If any changes to insurance occur during the patient's course of care, the office must be alerted to mitigate risk of claim denials in which the patient/guarantor may be financially responsible.

We will attempt to authorize and verify benefits but the responsibility is ultimately the patient's responsibility.

LATE CANCEL/NO-SHOW POLICY: We are committed to providing excellent quality and convenient physical therapy. In consideration of our patients and staff, we do require 24 hour notice for appointment cancellations. No-showing for an appointment creates a financial and scheduling burden, therefore we are forced to charge:

- $30 FEE FOR NO SHOW APPOINTMENTS AND CANCELS WITH LESS THAN 24 HOURS NOTICE.
- **This fee cannot be billed to your insurance!** **Yes Initials:_____**

While we understand that emergencies happen, appointments missed 3 times in a row or frequent cancellations may result in discontinuation of further appointments. Regular cancellations and no-shows will be documented and reported to your physician and/or insurance/third-party payor. This could affect the status of your claim.

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 PT PC to render both emergency and non-emergency healthcare services both in and out of my physical presence.
Ø I attest that I have read and understand the above: **Yes Initials:_____**

I attest to the fact that this is **NOT** a workers' compensation, motor vehicle claim, or third party claim. If the insurance that I supplied does not pay, I acknowledge that I am liable to pay in full for all services received. (If services are due to workers' compensation, motor vehicle accident or third party claim, please skip this section.)
Ø I attest that I have read and understand the above: **Yes Initials:_____**

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

Patient Last Name: _____ First Name: _____ DOB: _____

Signature of Patient/Legal Guardian:_____ Date:_____

Print name:_____ Relationship:_____

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NEW PATIENT DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION

First Name:_____ MI: ____ Last Name: _____ Sex: _____

Date of Birth: _____ Phone: _____ SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____ Email: _____

How did you hear about us? Social Media ☐ Google ☐ Physician ☐ Friend ☐

Recommended by: _____ Other: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship to patient: _____

GUARANTOR/RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Date of Birth: _____ Phone: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Email: _____

I AUTHORIZE PEAK PERFORMANCE TO DISCUSS PROTECTED HEALTH INFORMATION WITH:

1) Name: _____ Phone: _____

Relationship to patient: _____

Visit/Appointment Info: __ Billing/Payment Info: __ Medical Info: __ Other: _____

2) Name: _____ Phone: _____

Relationship to patient: _____

Visit/Appointment Info: __ Billing/Payment Info: __ Medical Info: __ Other: _____

May we leave messages regarding appointment information on your voicemail or text? **Yes___No___**

Appointment Reminders: *I understand that within the reminder, the location, date, and time of my appointment will be provided. Reminders are sent two days in advance.*

Initials _____

Patient Signature: _____

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NEW PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

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

Alcoholism: Yes ☐ No ☐ Smoke/Tobacco: Yes ☐ No ☐ Chemical Addition: Yes ☐ No ☐

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

PAST MEDICAL HISTORY

Please mark the following that are part of your <u>past and current</u> medical history:

Allergies (Latex, etc.)		Dizziness/off balance		Muscular Dystrophy	
Alzheimer's/Dementia		Fibromyalgia		Obesity	
Anxiety		Fracture (or suspected)		Osteoporosis/Osteopenia	
Blood Disorders		Gastrointestinal		Osteoarthritis	
Cancer		Headache/migraine		Parkinson's	
Cardiac Pacemaker		High Blood Pressure		Psoriasis	
Cauda Equina Syndrome		High Cholesterol		Rheumatoid Arthritis	
Chemical Addiction		Huntington's		Respiratory Disorders	
Congestive Heart Failure		IBS/UC/Crohn's		Sleep Disorders (apnea)	
COPD/Emphysema		Immunosuppression		Smoking/Tobacco Use	
Constipation		Incontinence		Stroke	
Current Infection		Insomnia		Thyroid Disease	
Depression		Lupus		Traumatic Brain Injury	
Diabetes - Type 1		Lymph Disorder		Urinary Disorders	
Diabetes - Type 2		Mood Disorder		Vascular Disorders	

Please explain any of the above marked conditions:

Surgical History: (type & date)

Medication List (continue on back if needed)	Dosage	Frequency	Route

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MUSCULOSKELETAL PAIN CONDITION

1. Name: _____ Date: _____

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

   How did it happen? _____

   What makes your symptoms better? _____ Worse? _____

2. Surgery/Procedures for this issue: Type: _____ Date: _____

   Precautions: _____

3. Other health services for this same problem: PT ☐ Chiropractor ☐ Acupuncture ☐ Massage Therapy ☐ Injections ☐

   If yes, please describe: _____

   Were they helpful? Yes ☐ No ☐

4. Test results for this issue (X-Ray, Labs, MRI, CT, etc.): _____

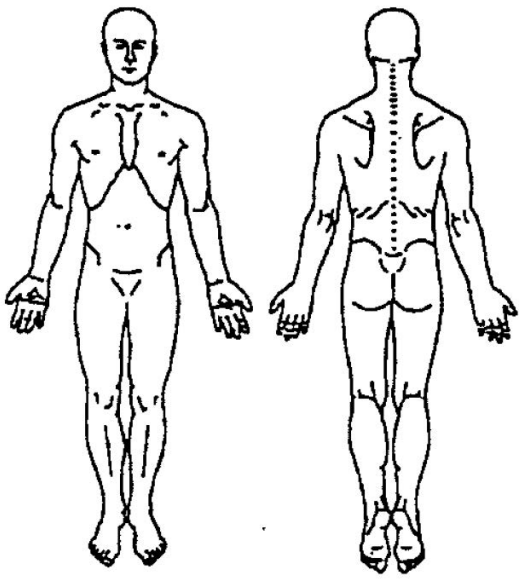
5. Rate your pain (0-10): *Now:* _____ *Worst:* _____ *Best:* _____

   Rate your ability to do things (1-100%): _____ Recreational/Sports: _____

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

6. Have you noticed any changes in: Bowel/Bladder Function ☐ Weakness ☐ Numbness ☐ Unexplained Weight Loss ☐

7. Current Work Status: Not Working ☐ Regular Work ☐ Second Job ☐ Modified Work/Limitations ☐ Retired ☐



Please mark your pain/discomfort on the diagram:

A: Ache

S: Stabbing

R: Radiating

N: Numbness

O: Other

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One Home for all Your Rehab Needs

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

Workers' Compensation Authorization

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

Date:_____

Adjustor Name:_____

Adjustor Phone #:_____

Adjustor Fax #:_____

Workers' Compensation Carrier:_____

Patient Name:_____

Date of Birth:_____ Claim#:_____

Claims Mailing Address:_____

_____

Claims Fax# (if different than the Adjustor fax):_____

For Adjustor to complete:

Please choose one of the following:

☐ Treatment is authorized as indicated in the prescription attached.

☐ Treatment is authorized as follows: _____

Frequency:_____

Duration: _____

Adjustor Signature: _____ Date: _____