PATIENT REGISTRATION FORM

Patient's Name: ____ Male Female
(First) (Middle Initial) (Last)

Address: ____ City: ___________________

State: __________ Zip: __________ Email: ___________________________________

Home: ______________________ Mobile: __________________ Work: ________________

SSN: ______/_______/________ Date of Birth: ____/____/______ Age: ________________

Employer: _____________________ Address: ______________________________________

Insured's Name: __________________ Date of Birth: ____/____/_____ SSN: _______________

Insured's Employer: _____________________________ Phone: ________________________

Employer's Address: ____

Date of Injury, if known: ________________ Date of Surgery, if applicable: ____________________

Referring Physician: _______________________ Referring Physician Phone: __________________

Emergency Contact Name: _____________________ Relationship: ________________________

Home: ______________________ Mobile: __________________ Work: ________________

How did you hear about PEAK Physical Therapy?

Physician Name: ______________________

Previous Patient Whom: ______________________

Friend/Family Whom: ______________________

Advertising Where: ______________________

Website / Internet Where: ______________________

Other Where: ______________________

PATIENT AGREEMENT

The information that follows is a statement of understanding regarding provision of physical therapy services. Please read the agreement carefully before signing. This contract will serve to clarify our working arrangement and facilitate prompt, efficient delivery of services.

I hereby authorize PEAK Physical Therapy & Sports Rehabilitation (PEAK PT) to administer and perform physical therapy procedures deemed necessary or advisable. I desire that physical therapy services be provided to me, my spouse or child and understand that I am financially responsible to PEAK PT for any and all charges incurred for physical therapy services rendered. **Initials: ______**

I agree to pay my co-pay at the beginning of each physical therapy session. I acknowledge that PEAK PT files insurance claims as a courtesy to the patient. Verification of insurance coverage is not a guarantee of benefits. Also, I understand that I am fully responsible for whatever charges my insurance company will not cover and/or denies. **Initials: ______**

I understand that I will be billed and responsible for paying a fee of $30 for a missed appointment or failure to notify PEAK Physical Therapy & Sports Rehabilitation of cancellation 24 hours prior to the appointment. If you are late by 15 minutes or greater for your appointment and have not called, you will not be seen and be considered a missed appointment. I agree to pay a fee of $35.00 for any check returned. (*These fees are not billable or covered by any insurance company and will be billed directly to the client/responsible party*). **Initials: ______**

In addition, I agree to pay any balances due within 30 days of the last of service rendered. I understand that my account will be considered delinquent and be charged interest at the rate of 18% per annum (1.5% per month) if there is any balance remaining on my account after these 30 days and will accrue until the account is paid in full. Also, I understand I am responsible for any and all fees including court costs and attorney's fees incurred as a result of collection efforts on this account. **Initials: ______**

Patient's Signature: ____________________________________ Date: ____________________

Printed Name: ______________________________________

Parent/Guardian: ______________________________________ Date: ____________________

Printed Name: ______________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I recognize that the information disclosed may contain information that is protected by federal and state law (HIPAA), and I specifically consent to disclosure of such information. I acknowledge that I have been informed, notified, and received a copy of PEAK Physical Therapy & Sports Rehabilitation's Notice of Privacy Practices.

I authorize PEAK Physical Therapy & Sports Rehabilitation to release the necessary information requested for insurance or legal purposes, or as requested by an authorized physician. I also authorize release of information from physicians or other health care facilities to PEAK Physical Therapy & Sports Rehabilitation as needed for physical therapy records.

I authorize PEAK Physical Therapy & Sports Rehabilitation to release information pertaining to treatment(s) provided to following individuals:

Name: ______________________________________ Relationship:____________________

Name: ______________________________________ Relationship:____________________

Name: ______________________________________ Relationship:____________________

I permit PEAK Physical Therapy & Sports Rehabilitation to leave detailed information about appointments or treatment(s) with a family member or on the answering machine/voice mail at home or mobile phone (please circle one):

YES: ______ **NO: ______**

Patient's Signature: _____________________________________ Date: _____________________

Printed Name: _______________________________________

Parent/Guardian: _______________________________________ Date: _____________________

Printed Name: _______________________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS STATED BY HEALTH INSURANCE PORTABILITY AND ACOOUNTABILITY ACT OR HIPAA, FOR SHORT. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we may ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

In general, HIPAA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:
Privacy Officer: Sasha Digges, Jr.
344 McLaws Circle Williamsburg, VA. 23185 757-564-7311

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Acknowledgement of Receipt of Notice of Physical Therapy Practices

Please sign, print your name and date on this acknowledgement form.

Patient's Signature: ___________________________________ Date: ____________________

Printed Name: _______________________________________

Parent/Guardian: _____________________________________

PEAK
PHYSICAL THERAPY &
SPORTS REHABILITATION

PERSONAL INVENTORY

1. What major complaint, symptom, or problem brings you here? ____________________

2. What activities, movements, or positions aggravate your condition? ____________________

3. What, if anything, relieves your symptoms? ____________________

4. Is your condition getting better, worse, or staying the same? ____________________

5. Please rate your pain on a scale on a scale from 0 to 10:
   (Circle the number that represents the best you feel and a number that represents the worst you feel)

   0 1 2 3 4 5 6 7 8 9 10
   no pain … *severe pain*

6. Please rate your ability to perform your normal activities on a scale from 0 to 10: *(circle one)*

   0 1 2 3 4 5 6 7 8 9 10
   unable … *normal*

7. What tests and/or treatments have you had for this problem (x-ray, MRI, chiropractic, etc…)? __________

8. What medications are you currently taking? ____________________

9. Have you been diagnosed with or experienced any of the following?

   Allergies
   Balance dysfunction
   Bowel/bladder problems
   Cancer: type: ____________
   Cardiac condition
   Chills/fever/sweats
   Depression
   Diabetes
   Dizziness
   Headaches
   High blood pressure
   Numbness/tingling
   Neurological conditions
   Osteoporosis
   Osteoarthritis
   Psychological condition
   Pregnancy
   Recent weight loss/gain
   Rheumatoid arthritis
   Thyroid condition
   Weakness

10. What are your goals for coming to physical therapy? ____________________