21195-B IH-35 North, Suite 201
Kyle, Texas 78640
512.268.0000 voice
512.268.0004 fax

Patient Information

Name: ______________________ Date: ______

Address: ______________________

____

Home: ______ Work: ______ Cell: ______

○ Male ○ Female ○ Married ○ Child Date of Birth: ______ Age: ______

SSN# (Medicare, Tricare and Workers Comp only): ______

E-mail: ______

Emergency Contact: ______ Number: ______

Is this treatment due to a Motor Vehicle Accident or Work Injury? Yes No Date of Injury: ______

Policy Holder Information for Personal Insurance or Medicare

Name: ______ Relationship to Patient: ______

Address: ______

______

Home: ______ Work: ______ Cell: ______

○ Male ○ Female Date of Birth: ______

SSN# (Medicare and Tricare only): ______

Employer: ______

Primary Insurance Carrier: ______

ID: ______ Group: ______ Phone Number: ______

Co-Pay: ______ Co-Insurance: ______ Deductible: ______ Max PT PCY: ______

Secondary Insurance Carrier: ______

ID: ______ Group: ______ Phone Number: ______

Co-Pay: ______ Co-Insurance: ______ Deductible: ______ Max PT PCY: ______

Workers' Comp Information

Employer: ______ Phone: ______

Adjustor: ______ Phone: ______

Claim Number: ______

Treatment Information

Referring Physician: ______________________ Phone: __________

Date of first doctor visit for this injury: __________ Date of Injury: __________

Have you had surgery for this injury? Yes No Date of Surgery: __________

Current Medications: ______________________

____

How would describe your present health? Excellent Good Fair Poor

Have you had any of the following medical or rehabilitative services **for this injury**?

☐ Physical Therapy ☐ Occupational Therapy ☐ Chiropractor
☐ Neurologist ☐ Orthopedist ☐ Emergency Room Care
☐ CT Scan ☐ MRI ☐ X-ray

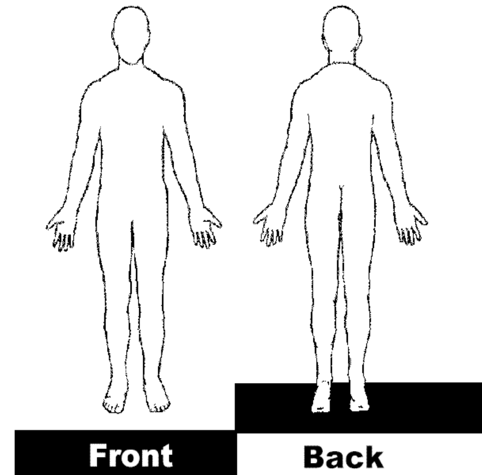
If you checked one of the above boxes, how many visits? __________

What are the specific goals you would like to accomplish with physical therapy? __________

____

____

Please mark the location(s) of your current symptoms on this diagram. If symptoms, which pertain to your current injury, are in more than one area, please be sure to include all areas on the diagram.



Do you have a follow-up appointment scheduled with your doctor? Yes No

If yes, please provide the date. __________

Patient Health Information

Have you ever had any of the following? Please check all which apply:

☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Clot/Emboli
☐ Bowel/Bladder Issues
☐ Bronchitis
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Emphesema
☐ Emotional Disorders
☐ Epilepsy
☐ Fainting
☐ Head Injuries

☐ Hearing Problems
☐ Heart Disease / Angina
☐ Hernia
☐ Heart Attack/Surgery
☐ High Blood Pressure
☐ Infectious Disease
☐ Mental Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Pins/Metal Implants
☐ Severe Headaches
☐ Shortness of Breath / Chest Pain
☐ Sleeping Problems
☐ Stroke/TIA
☐ Swollen Joints
☐ Varicose Veins

☐ Vision Problems
☐ Weakness
☐ Weight/Energy Loss

☐ Are you pregnant?
☐ Do you smoke?

Injury and/or Surgery:

☐ Neck Date: __________
☐ Shoulder Date: __________
☐ Elbow Date: __________
☐ Back Date: __________
☐ Knee Date: __________
☐ Leg Date: __________
☐ Ankle Date: __________

Peak PHYSICAL THERAPY & SPORTS MEDICINE CENTER

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Insurance / Financial Responsibility

- Peak does not accept PIP, 3rd Party (Auto) Insurance, or Letters of Protection (LOP's).
- Workers' Comp patients must provide the name and phone number of their adjustor and approval must be obtained before treatment can begin.
- **Peak will not bill Private Insurance for Auto or Work injuries.**
- Deductibles, Co-pays, and Co-insurance are due at the time the service is rendered.
- **Medicare patients receiving home health services of any kind are NOT eligible for outpatient physical therapy.**
- I **authorize Peak to release all information necessary, including Medical Records, to secure payment**. I understand, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
- **Benefits quoted to Peak Physical Therapy by your insurance company over the telephone are not a guarantee of payment**, and in some instances incorrect information is quoted by your insurance company. We recommend you call your insurance to confirm your benefits.

Signature: ______________________ Date: __________

Permission for Treatment and Release of Medical Records

- This is to certify I, undersigned, **give Peak consent for care and treatment** considered necessary and proper in evaluating and treating my condition. As well, my physician may release MRI, CT Scan, or other reports to Peak.
- To the best of my knowledge, **all of the preceding answers and information provided are true and correct**. If I ever have any change in my health, I will inform the therapist at the next appointment without fail.
- I **authorize Peak to release necessary medical records with my physician, attorney, claims adjustor and insurance company if the need arises**.
- I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time.

Signature: ______________________ Date: __________

The Patient's Commitment to Care

- **Please arrive on time**. Failure to arrive within 10 minutes of your scheduled time or cancelling your appointment within the hour will result in a $20 charge.
- **Please refrain from making cell phone calls / texting during your therapy session**. Emergencies are the exception.
- Please dress appropriately. If you need to change, you may do so in the restroom. Please arrive early if you need to change clothes before beginning therapy.
- Please refrain from using profanity.
- Please remain in the waiting room until you are called into the gym. However, you may enter the gym if you need to use the restroom, get a drink of water, or change for a session.
- **If you are sick** (running a temperature, vomiting, have diarrhea, or an infectious virus), **please call before coming to the clinic** – as you may be asked to stay home for your own health/welfare, as well other patients and the staff.
- **Please notify the staff of any scheduled follow-ups with your doctor**. Doing so will allow us to take measurements and prepare a report for your doctor. A minimum of two day's notice is required.

Thank you for your cooperation. With your help in adhering to the above expectations, we can focus on your rehab and provide superb care.

Signature: ______________________ Date: __________