Medical History Information

Current Medications: (list here or bring us a list) _____

Allergies (including drugs)? _____ Allergic to latex? Yes / No

Work Status: _____ Occupation: _____

How would you describe your present health? Excellent Good Fair (circle one)

Have you had any of the following medical or rehabilitative services for this injury? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Chiro

☐ Physical Therapy ☐ Occupational Therapy ☐ Neurologist ☐ Orthopedist ☐ Emergency Room

What are the specific goals you would like to accomplish with Physical Therapy? _____

Did you see the Dr. for this specific body part? If so, when: _____ Date of injury/surgery for this body part _____

Medicare Insurance – In the past 60 days has someone come into your home to provide services like Home Health Care? If yes, you are not eligible for outpatient physical therapy service until discharged for 24 hours. Discharge date: _____

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

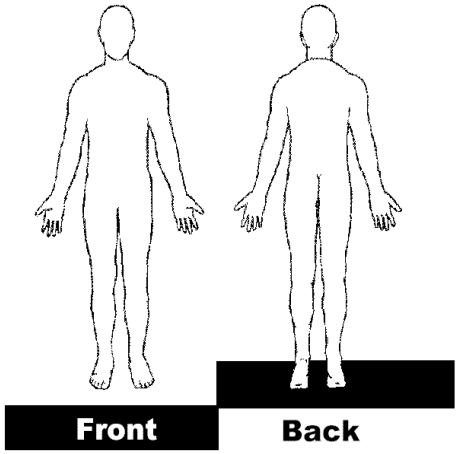
☐ Allergies	☐ Emphysema	☐ Pacemaker	Surgery:
☐ Anemia	☐ Emotional Disorder	☐ Pins/Metal Implants	
☐ Arthritis	☐ Epilepsy	☐ Severe Headaches	☐ Neck Date: _____
☐ Asthma	☐ Fainting	☐ Shortness of Breath/Chest	☐ Shoulder Date: _____
☐ Blood Clot/Emboli	☐ Head Injuries	☐ Sleeping Problems	☐ Elbow Date: _____
☐ Bowel/Bladder Issues	☐ Hearing Problems	☐ Stroke/TIA	☐ Back Date: _____
☐ Bronchitis	☐ Heart Disease/Angina	☐ Swollen Joints	☐ Knee Date: _____
☐ Cancer	☐ High Blood Pressure	☐ Varicose Veins	☐ Leg Date: _____
☐ Chemotherapy	☐ Infectious Disease	☐ Vision Problems	☐ Ankle Date: _____
☐ Diabetes	☐ Mental Disorders	☐ Weakness	
☐ Dizziness	☐ Osteoporosis	☐ Weight/Energy Loss	

☐ **OTHER:**

_____

Fall risk assessment:
Are you seeing a physician for dizziness or imbalance? Yes / No
Do you have loss of balance or require assistance when getting up from sitting? Yes / No
Do you have difficulty walking without holding onto furniture or walls? Yes / No
Do you use an assistive device for walking (i.e., cane, walker)? Yes / No
Have you fallen with in the last 12 months? Yes / No If yes, how many times? _____

On the diagram, please mark the location(s) of your current symptoms. 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 any pain related to your current problem? Yes / No
If yes, circle the pain/symptoms:

throbbing, dull, sharp, numbness, burning, shooting, prickling, gnawing, heavy, tingling, aching, pressure, comes and goes, stays all the time.

Pain Scale is 0 – 10: 0 = none / 10 = severe
My pain today is: _____

In-Network Consent & Agreement_____

Based upon my In-Network insurance benefit coverage for Physical Therapy, I agree to the following payment terms and conditions:

Today's Charge: $_____ for initial evaluation. Depending on your insurance plan you may have a deductible, coinsurance, or copay that applies to future visits.

Payments collected in the office for deductible and co-insurance are **not** considered as payment in full. Amounts paid in this signed agreement are **strictly estimated amounts** collected and will be applied to your visits after insurance has processed your claims and applied to **your patient responsibility**. ***The final amount may change based on your insurance processing. Any remaining amounts for either deductible or co-insurance are your responsibility and will be billed to you.***

Explanation of Benefit Information- Benefits quoted to Peak PT by your insurance company are not a guarantee of payment, and in some instances incorrect information is quoted by your insurance company. We recommend you call your insurance company to confirm your benefits. I authorize Peak PT 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 services I receive, I will be financially responsible for payment. Your portion of the bill mailed to you must be paid within 30 days of the billing date. Any unpaid balances will be considered past due and will be sent to collections with a 10% fee added after 60 days. Deductibles, Co-pay, Co-insurance, etc. are due at the time of services rendered.

Please Initial: _____

Permission for Treatment and Release of Medical Record- I give Peak Physical Therapy consent for care and treatment necessary in evaluating and treating my condition. Also, my physician may release MRI, CT scan, or other reports to Peak PT. I authorize Peak PT to release necessary medical records to my physician. I have chosen not to receive a copy of the privacy policy. I understand a copy is available at any time.

Please Initial: _____

The Patient's Commitment to Care- We assure you that you will receive the best care available for your condition.

- **Please arrive on time.** Failure to be on time will result in possibly being rescheduled and a **$35.00 late fee.**
- **If you cancel the day of your appointment or do not show up a $50 fee will automatically be charged to your account balance.** After 2 cancellations or no shows we will discharge or remove your remaining scheduled appointment. You must contact us to reschedule. To cancel your appointment, you must call during business hours at least 24 hours in advance.
- Do not make cell phone calls or text during your therapy session. Emergencies are the exception.
- If you are ill (running a temperature. vomiting, diarrhea, cough, or an infectious virus), please call before you come into the clinic as you may be asked to reschedule for your own health, as well as other patients and staff.
- Notify staff 48 hours in advance of any scheduled follow-up with your doctor. This will allow us time to prepare a report.

Credit Card Payment Authorization – We will securely save your credit card information within our system as this is our clinic policy required by our billing company. This will speed up your check-in process. I understand that this authorization will remain in effect until I cancel it in writing.

Yes, I Agree _____ No, I do not Agree _____

With your help adhering to the above expectations, we can focus on your rehabilitation and provide superb care.

Your Email: _____ to receive your home health exercises.

Emergency Contact: _____ Relationship: _____ Phone: _____

Signature of Patient/Guardian: _____ Date: _____

Appt. Date/Time/Day: _____ Therapist/FD: _____