PATIENT GUIDELINES

*Welcome and thank you for selecting **Peak Physical Therapy and Sports Performance** for your physical therapy care.*

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel free to contact any member of our team with questions or if you need any information.

Wishing you good health,

Peak Physical Therapy and Sports Performance

- **Primary Care Referrals** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
- **Co-Payments** Co-Payments must be paid upon the patient's arrival. We accept cash, check, Visa, MasterCard or American Express. Debit cards are also accepted.
- **Non-covered services** Supplies and equipment must be paid for at the time of service.
- **Attire for Physical Therapy** Shorts or sweatpants with an elastic waistband may be ideal, particularly if we are treating the lower extremities. Loose-fitting clothing is recommended for treatment of the upper extremities.
- **Tardiness** Please call if you are running late. Physical therapy treatments may be abbreviated for patients arriving 10-15 minutes late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time- if we are running late, the session will be completed in its entirety.
- **Cancellations** We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment slot. If a cancellation and/or missed appointment without notification is made with less than 24 hours notice, and the patient is unable to reschedule within 48 hours of the missed appointment a $30.00 fee will be collected. Monday appointments cancelled after 4pm on Friday will be considered less than 24 hours notice.
- **Repeated Missed Appointments** We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our treatment plan.

I have read and understand the above guidelines.

_____ _____

Signature of Patient or Responsible Party Date

PEAK PHYSICAL THERAPY AND SPORTS PERFORMANCE

PATIENT HISTORY FORM

Name_____ **Sex** _____**Date of Birth**_____

Height _____ **Weight** _____

Please complete all required information. Use reverse side, if needed, for additional space

1. Do you or have you ever had?

High Blood Pressure	No ☐ Yes ☐	Breathing Problems	No ☐ Yes ☐
Heart Trouble	No ☐ Yes ☐	Fracture	No ☐ Yes ☐
Circulation Problems	No ☐ Yes ☐	Stroke	No ☐ Yes ☐
Seizures	No ☐ Yes ☐	Arthritis	No ☐ Yes ☐
Dizzy Spells	No ☐ Yes ☐	Diabetes	No ☐ Yes ☐
Claustrophobia	No ☐ Yes ☐	Incontinence	No ☐ Yes ☐
Pneumonia	No ☐ Yes ☐	Depression	No ☐ Yes ☐
Chest Pain	No ☐ Yes ☐	Pain at Night	No ☐ Yes ☐
Blood Clots	No ☐ Yes ☐	Leg swelling	No ☐ Yes ☐
Osteoporosis	No ☐ Yes ☐	Osteopenia	No ☐ Yes ☐
Recent falls	No ☐ Yes ☐	(*In the last year)	
Cancer	No ☐ Yes ☐		
Other Illness	No ☐ Yes ☐	_____	

2. Have you ever had Surgery? No ☐ Yes ☐ If yes, give Date(s), Operation(s), and Outcome(s)

_____

3. Do you have any metal anywhere in your body (other than your teeth)? No ☐ Yes ☐
4. Do you have a Cardiac (heart) Pacemaker? No ☐ Yes ☐
5. (For Women Only) Are you now pregnant? No ☐ Yes ☐ Date of last period_____
6. List medical tests done for this condition_____

_____

7. List any Allergies you have_____

_____

8. Have you ever had Physical Therapy treatments before? No ☐ Yes ☐
   If Yes, indicate Where, When and for What problem_____

_____

9. Describe briefly the history of your present accident or illness_____

_____

10. Please list prior accidents or work injuries_____

_____

11. Work Status ☐Regular Duty ☐ Light Duty ☐Off Duty

12. Any recent hospitalizations?_____

13. Do you live alone? _____Do you rely on anyone for assistance during your day? _____

14. How many stairs to enter your home?_____How many stairs inside your home?_____

15. Are there handrails with the stairs?_____

16. What floor is your bathroom/shower on?_____Bedroom?_____

18. Please list all of your medications with dosages: (Or supply a medication list)

MEDICATION	**DOSAGE**

For additional space, please write on the reverse side of this page.

Date

Signature

If not Patient, indicate relationship (Parent, Guardian, Other)

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

PEAK PHYSICAL THERAPY AND SPORTS PERFORMANCE, INC

EFFECTIVE DATE APRIL 4, 2005

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Eric Edelman, PT at (781)347-4686.

WHO WILL FOLLOW THIS NOTICE: Peak Physical Therapy and Sports Performance, INC

This notice describes our privacy practices.

OUR PLEDGE REGARDING HEALTH INFORMATION:
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you;
- and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Eric Edelman, PT, at (781)347-4686.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Eric Edelman, PT. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Peak Physical Therapy and Sports Performance.

X_____ Date _____
Signature

In lieu of patient signature, I, _____, a staff member of Peak Physical Therapy and Sports Performance, state that _____ has been given our current Notice of Privacy Practices.

X_____ Date _____
Signature

Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes_____ No_____

B. Is there any individual, besides your doctor and involved health care practitioner(s), with whom Peak Physical Therapy and Sports Performance has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	Y____	N____	_____
Son/Daughter	Y____	N____	_____
Son-in-law/Daughter-in-law	Y____	N____	_____
Friend	Y____	N____	_____
Other	Y____	N____	_____

AUTHORIZATION POLICY STATEMENT

We would like to thank you for choosing Peak Physical Therapy and Sports Performance, INC and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the least cost.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy.

RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the present time.

POINT OF SERVICE COLLECTIONS

Payment for service is due at the time to service(s) is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.
Payment will be accepted in cash, checks, MasterCard, Visa or American Express card. We will be happy to file verified insurance on your behalf. Patients unable to comply with the Point-of-Service payment policy will be referred to the administrative office for necessary arrangements.

PAYMENT ARRANGEMENTS

The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the clinic's discretion, based on the amount of the patient's liability and the patient's ability to pay based on a completed credit application.

PATIENT SCHEDULING

Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic payment policy at the time appointments are made along with the best estimate of the cost of the office visit.

ACCEPTANCE OF INSURANCE

The clinic will accept "Assignment of Benefits" on verified insurance policies and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits as a courtesy to the patient, prior to the acceptance of payment for services. It is, however, the responsibility of the patient to know his/her own physical therapy benefit, including copay and deductible amounts that apply.

AUTHORIZATION WAIVER

Please make sure you have called your Primary Care Physician or your Insurance Carrier to confirm that authorization is in place for these services. Authorization can only be generated by your primary physician, as we do not wish for you to pay for these services yourself.

REJECTED CLAIM

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf. P15

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

Please initial that you have acknowledged the above policies: _____

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic. Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not. The clinic cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the clinic interest.

BAD DEBTS/ LEGAL ACTION

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the clinic reserves the right to refer the account to an attorney and/or a collection agency for the collection of the balance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fee.

AUTHORIZATION FOR TREATMENT

I hereby authorize the physical therapists at Peak Physical Therapy to administer treatments as are deemed necessary or advisable in the diagnosis of my care.

RELEASE OF RECORDS

I hereby authorize other healthcare providers who are or have been involved in my care to release my medical records to this facility/unit.

I hereby authorize the facility/unit to transfer copies of my medical records to any other healthcare provider that is involved with my care while I am a patient of the facility or to whom I may be transferred to during my course of treatments.

I hereby authorize the facility/unit, any insurance company, claims or benefit administrator, pre-payment organization, governmental agency or health care provider to obtain information and provide information (including medical information and financial records) necessary to process an application for insurance, Medicare or Medicaid benefits, to determine the availability for benefits that may be available and to obtain required pre-authorizations and re-authorizations.

The administrative and management welcomes the opportunity to discuss any aspect of the authorization policy. We appreciate your confidence and strive to provide quality healthcare.

I have read the *Financial Policy/ Policy Statement* and understand regarding above.

_____ _____

Patient/Guarantor Date

_____ _____

Witness-Staff Employee Date