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:_______________________________________

PEAK PERFORMANCE
PHYSICAL THERAPY & SPORTS MEDICINE
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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 past and current 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.): ______________________________

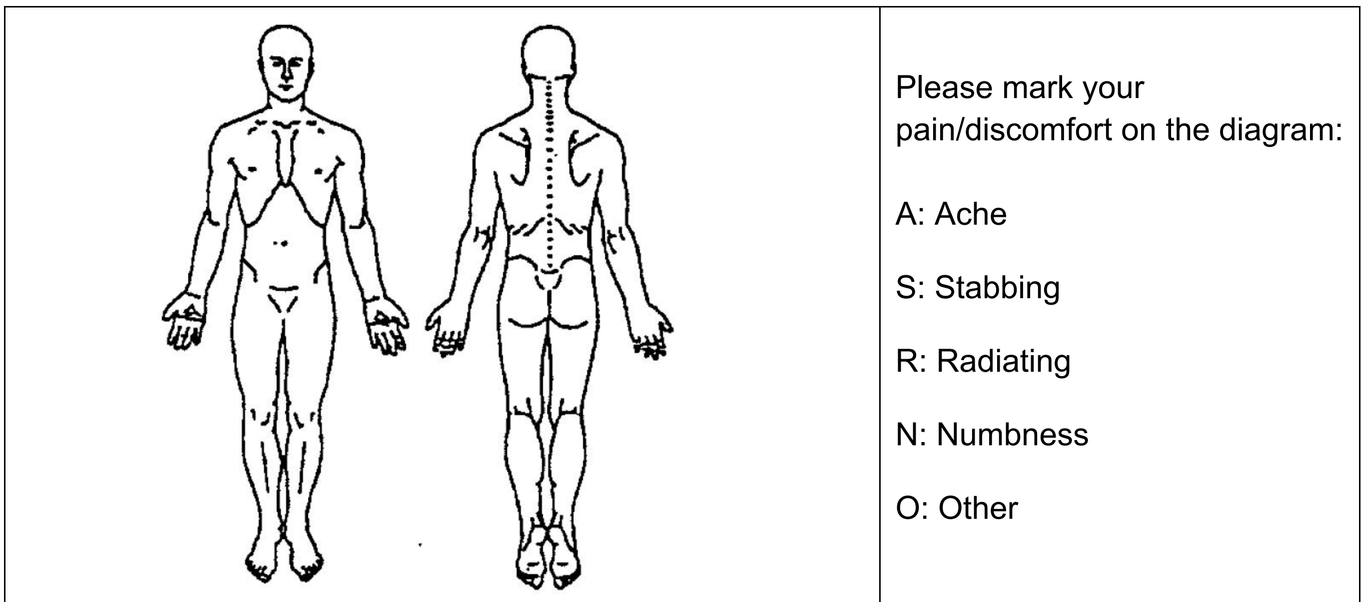
5. Rate your pain (0-10): *Now:* _____ *Worst:* _____ *Best:* _____

   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 ☐



One Home for all Your Rehab Needs

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

Motor Vehicle Questionnaire

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

Is this a third party claim?(Please circle one) YES NO

If yes, we will need also need the patients' auto insurance information with claim # and adjustor information.

Name of Patient:____

Date of Birth: ____

Patient Phone Number:____

Date of Accident:____

State the accident was in:____

Claim #:____

Insurance Company Name:____

Adjustor Name:____

Adjustor Phone:______________________ Adjustor Fax:______________________

Claims Mailing Address:____

____

Claims Fax (if different than Adjustor Fax):____

Is the claim open and billable?(Please circle) YES NO

Is the Insurance Company listed above accepting responsibility?(Please circle) YES NO

Is there a cap on benefits?(Please circle) YES NO

If yes, what is the cap amount?____

Is there an Attorney involved? (Please circle one): YES NO

Attorney's Name:____

Attorney's Phone Number:____

Once Adjustor (and Attorney if acquired) has confirmed information provided above is correct, patient can be scheduled.

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Dear Patient,

Thank you for choosing Peak Performance Physical Therapy. Our policy regarding motor vehicle claims is that we can only carry $1,000 on your account at any one time.

If we are billing third party, we should also have your auto insurance information.

At no time will we be able to bill your private healthcare insurance.

Peak Performance Physical Therapy will bill after each visit so that they will receive the claim in a timely manner.

You will be notified if we are approaching the $1,000.00.

Ultimately you are responsible for payments of bills incurred.

If at any time you hire an attorney, we must be notified immediately so a lien can be sent.

If you will be self-submitting claims, please initial here to acknowledge that you are responsible for the services rendered at time of visit. **Initials:___________**

Please do not hesitate to contact us with any questions you may have regarding our policy. Again, thank you for choosing Peak Performance Physical Therapy for your rehab needs.

Patient Signature: ____ Date: ____________________

Print Name: ____

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Lien for Physical Therapy Services

TO:______________________________

____

____
(Insurance Company/Attorney)

RE:__________________________________ Claim#:__________________________________
(Patient Name)

NOTICE OF LIEN:

You are hereby given that Peak Performance Physical Therapy claims a lien for services rendered to

____________________________________ From __________________ To __________TBD____________
(Patient Name) (First Date of Service)

That total the amount being $______TBD_____________

The nature of the services rendered and an itemized statement showing the value of such services is submitted herewith and incorporated by references.

This lien is claimed pursuant to the ***Physician, Nurse, and Physical Therapist…Lien Act, 71-3-1111 to 71-3-1118 MCA.*** This act provides that "If any insurer or person, service, or death and the amount of the lien ***claimed by any physician, nurse, or physical therapist…has not been paid***, the insurer or person is liable to the physician, nurse or physical therapist.. for the reasonable value of the services. (71-3-1117, MCA)
Dated this _______________________ Day of __________________ of ____________________
(Day) (Month) (Year)

Sincerely,

Peak Performance Physical Therapy

Employee Sign____ Date __________________________