

Patient Name _____ Sex _____ Date of Birth _____

Today's Date: _____

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

- **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.
- **Cancellations** We request that patients who are unable to keep an appointment contact our office **by 5PM the night prior to the scheduled appointment time** since there are usually other clients that could benefit from this treatment slot. If we are not notified about a cancellation and/or missed appointment before 5PM the night prior, and the patient is unable to reschedule within 48 hours of the missed appointment, a **\$30.00 fee** will be collected. **Monday appointments must be cancelled prior to 12PM on Saturday to avoid the \$30 fee.** If a cancellation and/or missed appointment without notification is made after 5PM the night prior (or after 12PM on Saturday for Monday appointments) for an Aquatics, Women's Health, Men's Health, or Pediatric Pelvic Health appointment, a **\$75.00 fee** will be collected. For these specialized programs, rescheduling will not be offered in lieu of the fee. If there are three or more cancellations, even with appropriate notice, all future appointments may be taken out at the discretion of your therapist.
- **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 PEDIATRIC CENTER

PATIENT INFORMATION:

Child's Name: _____

Age: _____

Date of Birth: _____

Gender: _____

Name of Parent/Guardian/Caregiver: _____

Referring Provider: _____ Location: _____

Primary Care Provider: _____ Location: _____

What are your primary concerns for having your child evaluated and treated? _____

PREGNANCY/BIRTH HISTORY:

Did mother have any illnesses or complications during pregnancy or delivery? Circle One: YES NO

Did your child require any medical procedures before, during or after birth? Circle One: YES NO

Did your child require hospital stay or time in NICU? If yes, how long? Circle One: YES NO

Was your child premature? If yes, how many weeks & their weight? Circle One: YES NO

MEDICAL HISTORY:

PLEASE CHECK OR LIST ANY ILLNESSES OR CONDITIONS:

SEIZURES

EAR INFECTION/PE TUBES

DIABETES

ASTHMA

HEART DEFECT/CARDIAC ISSUES

TORTICOLLIS

GERD/REFLUX

ABNORMAL MUSCLE TONE

BIRTH INJURIES

OTHER: _____

Name of Medication	Dosage	Frequency	Reason for Medication

What (if any) special equipment does your child use? (list): _____

Is your child's vision within normal limits? _____

Has your child's hearing been evaluated? _____



Allergies: _____

Please list all surgeries and dates: _____

Does your child ever complain of pain? If so in what area? Please describe. _____

Any Behavioral Concerns (ex: cries often, rocks self, anxious, difficulty separating, etc.) _____

Is there any known history of the following in the immediate or extended family? Please check or list any:

Autism/PDD

ADHD

Learning Disabilities

Hearing Loss

Speech/Language Delays

Developmental Delays

OTHER: _____

DEVELOPMENTAL HISTORY / MILESTONES:

Milestone:	Months/Years
ROLLED OVER	
SAT	
CRAWLED	
STOOD WITHOUT HELP	

Please list any motor developmental concerns you may have: (ex: gross motor, fine motor, motor planning, fear of movement, etc.) _____

LIST OF NAMES OF PROGRAMS

Services	Practice Name	Date(s) of Service
Occupational Therapy		
Speech Therapy		
Physical Therapy		
Early Intervention		

Does your child receive any therapy services through school? If yes, please explain. _____

Does your child have an individualized education plan (IEP) or 504? If yes, please explain: _____

What typically calms/soothes your child? _____

What are your child's favorite toys? _____

Is there anything else that you feel would be beneficial for us to know about your child? Please specify: _____

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.

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.

PARENTS/GUARDIANS OF MINOR PATIENTS

If your child is under the age of 18, we request that you please accompany your son/daughter for at least a portion of the physical therapy appointments. Your attendance is required to allow your therapist to communicate your child's care, schedule appointments, etc... here at Peak Physical Therapy Inc.

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. Payment will be accepted in cash, checks, MasterCard, Visa or American Express card. 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.

PAYMENT ARRANGEMENTS

Payment for services are due at the time of the service. 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.

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.

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.

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.

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.

****MEDICARE HOME HEALTH CARE SERVICES****

Please note: Medicare will NOT authorize or pay for treatment of outpatient physical therapy services provided if ANY Medicare home health care services are being rendered. If Medicare home health care services *are* being provided, patients will be responsible for payment of all services rendered by Peak Physical Therapy, Inc.

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.

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. 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.

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.

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, acknowledge, and agree to the **Authorization Policy Statement, the *Financial Policy/ Policy Statement* and the Notice of Privacy Practices from Peak Physical Therapy, Inc.**

Print Name of Patient/Guarantor

Date

Signature of Patient/Guarantor

Date

Memorandum of Understanding for Non-Covered/Self-Pay Services and Items

This memorandum is being provided to you specifically to outline **optional** items and/or services which are offered at our facilities for an additional self-pay fee. These items/services are **not** covered by your health insurance carrier, and/or will **not** be billed to your health insurance carrier.

<u>Items / Services Not Covered:</u>	<u>Fee</u>
Self-pay physical therapy evaluation (60 min.)	\$140
Self-pay physical therapy treatment session (30 min.)	\$80
Single dry needling half hour treatment	\$60 (5 for \$240)
Dry needling (as part of scheduled physical therapy)	\$20
Clogged Milk Duct Treatment (30 min.)	\$80
Cold laser treatment (maximum 3 laser points)	\$10
Specialty electrodes	\$50
Iontophoresis Pads	\$10
Thera-band	\$5

Agreement and Understanding:

Your signature indicates your complete understanding of your financial obligation if you choose to participate in any of these above services/items. If at any point throughout the course of your care you would like to participate in any of the above services, please communicate this to your therapist.

Signature of Patient/Legal Guardian **Date** _____