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, or Men's Health appointment, a $50.00 fee will be AUTOMATICALLY CHARGED. Same-day cancellations for pediatric appointments will result in a $75.00 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

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PEAK CARE. PEAK RESULTS.

Women's Health Questionnaire

1. **Describe the current problem that brought you here? _____**
   _____

2. **When did your problem first begin? _____**

3. **Since that time, is it**: ____ staying the same _____ getting worse ____ getting better.
   Why/ How?_____

4. **If pain is present, rate pain from 0 to 10 with 10 being the worst, in the LAST WEEK:**
   Current:_____Best:_____Worst:_____

5. **Describe previous treatment for this problem**._____

6. **Activities/events that cause or aggravate your symptoms. Check / circle all that apply.**
   ___sitting greater than _____minutes
   ___walking greater than_____minutes
   ___standing greater than_____minutes
   ___caring for family
   ___changing positions (I.E. sit to stand)
   ___with environmental triggers (ie: running water/ key in door)
   ___vigorous activity/exercise
   ___light activity (light housework)
   ___no activity affects the problem
   ___other; please specify:_____
   ___with cough/sneeze
   ___with sexual activity
   ___with lifting/bending
   ___with specific food/fluid intake
   ___with cold weather
   ___with nervousness/anxiety
   ___work; please specify:_____
   ___social activities; please specify:_____

7. **What relieves your symptoms? _____**

8. **Bladder Symptoms (if applicable)**
   -How often do you urinate during the day?_____Overnight?_____
   Please check all boxes that apply
   -Is your urine stream: Hesitant ☐; Slow ☐; Intermittent ☐; Difficult to Stop ☐
   ☐ Trouble emptying bladder
   ☐ Straining to empty bladder
   ☐ Trouble feeling urge to urinate
   ☐ Urine leakage- (if so, describe):_____
   ☐ Blood in urine
   ☐ Recurrent bladder infections
   ☐ Painful urination
   *-If you answered yes to urine leakage, what do you use for protection & how many per day?
   ☐ Pads:_____ ☐Tissue paper:_____ ☐Briefs:_____
   ☐ Other_____

9. **Bowel (if applicable)**
   -How often do you move your bowels?:_____
   -What is your typical stool consistency?:_____
   Please check all boxes that apply
   ☐ Trouble fully emptying bowels
   ☐ Straining to empty bowels
   ☐ Trouble feeling urge to have bowel movement
   ☐ Fecal leakage- (if so, describe):_____
   ☐ Blood in stool
   ☐ Use medications
   ☐ Pain with bowel movements
   ***-**If you answered yes to fecal leakage, what do you use for protection & how many per day?
   ☐ Pads:_____ ☐Tissue paper:_____ ☐Briefs:_____
   Are you able to hold back gas when needed? ☐ Yes ☐ No
   Do you experience other GI or abdominal issues? ☐ Yes ☐ No; If yes, describe:_____
   _____

10. Sexual (if applicable)

-Are you currently sexually active? ☐ Yes ☐ No
-Pain during or after: Intercourse: ☐Yes / ☐No; Orgasm: ☐Yes / ☐No;
Arousal: ☐Yes / ☐No; External Touching: ☐Yes / ☐No
-Decreased sensation during sexual activity or intercourse? ☐Yes ☐ No
-Increased sensation during sexual activity or intercourse? ☐Yes ☐ No
-Physical, sexual, verbal, or emotional abuse or trauma? ☐ Yes ☐ No
-Other:_____
_____

11. OB/GYN History (females only)

-How old were you when you started menstruating?:_____
-Do you or did you experience pain with menstruating? ☐ Yes ☐ No
-When was the date of your last period?_____
-Do you experience pain with gynecological exams? ☐ Yes ☐ No
-Have you had any pregnancies? ☐ Yes ☐ No
-If yes, please list date of delivery, type of delivery, and any complications:
_____
_____
_____
_____
_____
-Have you gone through menopause? ☐ Yes ☐ No
-Do you experience vaginal dryness? ☐ Yes ☐ No
-Do you experience or has a doctor told you that you have pelvic organ prolapse? ☐ Yes ☐ No
-Other:_____
_____

12. Past Medical History (please check all that apply)

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Diabetes
☐ Heart Disease/ Pacemaker
☐ HIV/ AIDS
☐ Previous Stroke
☐ Circulatory Problems/ Blood Clots
☐ Leg Swelling
☐ Arthritis
☐ Neurological Disorders; specify:_____
☐ Osteoporosis
☐ Asthma/ Breathing Problems
☐ Allergies
☐ Depression
☐ Falls in the past year

-Do you have any other orthopedic problems/concerns? Please describe:_____
_____
_____

13. Any recent hospitalizations?_____

Do you live alone? ☐ Yes ☐ No
Do you rely on anyone for assistance during your day? ☐ Yes ☐ No
How many stairs to ***enter*** your home?_____; How many stairs ***inside*** your home?_____
Are there any handrails with the stairs?_____
What floor is your bathroom/shower on?_____; Bedroom?_____

14. **Surgical History**

_____

_____

_____

_____

15. **Medications/Dosages**

_____

_____

_____

_____

16. **Have you ever had PT before?** ☐ Yes ☐ No

If yes, when and for what?:_____

17. What are you preferred pronouns? ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs

☐ Other:_____

Written Consent of Physical Exam

The pelvic floor muscles are a group of muscles that surround the pelvic organs (urethra, vagina, anus) and are responsible for maintaining continence, supporting the pelvic organs as well as maintaining a healthy sexual response.

After thorough discussion of your current condition and symptoms and if deemed appropriate, I will be completing a physical assessment of your muscles. Assessment of the pelvic floor muscles is completed manually through the vagina or the rectum (depending on your symptoms and gender). Unlike a medical examination, this assessment of the pelvic floor muscles does not involve the use of a speculum or stirrups. Assessment of this area is important for diagnosis and allows the physical therapist to outline the best plan of care to improve your health. You may opt out of the internal portion of physical therapy prior to assessment and any time during treatment.

We welcome a trusted friend or family member to be present during the evaluation and/or subsequent treatments.

I, _____(signature), consent to the above stated internal assessment on_____(today's date).

Side effects of assessment/treatment may include: intramuscular cramping, emotional response, pain and rarely light spotting/bleeding. Please discuss any of these symptoms with your physical therapist.

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/patient account? If so, please print the individual's name and relation below:

Name:_____ Relation:_____

Name:_____ Relation:_____

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.

Items / Services Not Covered:	**Fee**
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**_____

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.

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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

_____ _____