

PEAK PERFORMANCE PHYSICAL THERAPY

PLEASE PRINT LEGIBLY

PATIENT INFORMATION			
NAME: (Last Name, First Name, Middle Initial)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:
Address: (Street / Apt #)		Date of Birth:	Status: <input type="checkbox"/> Married <input type="checkbox"/> Student <input type="checkbox"/> Single <input type="checkbox"/> Other
Address: (City, State, Zip Code)		Telephone # (Home):	Telephone # (Cell):
Name of Employer:		Telephone # (Work):	
Name of Referring Physician:		Name of Primary Physician:	
Is Your Visit Related To A Recent Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery Date:	Is This Due to A Worker's Comp Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Injury:	Is This Due To A Motor Vehicle Accident/Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident:	
Have You Had Physical Therapy Before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, When & What For?		
EMERGENCY CONTACT			
Emergency Contact: (Last Name, First Name)		Telephone #:	Relationship:
GUARANTOR / RESPONSIBLE PARTY (Must Be Completed, If Patient Under 18 Years of Age)			
Responsible Party's Name: (Last Name, First Name)		Telephone #:	Date of Birth: Relationship:
Address: (If Different Than Patient's Address Above)			
INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY:		POLICY # / ID #:	GROUP #:
INSURED PARTY: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Unknown	NAME OF INSURED PARTY:		INSURED PARTY DOB:
SECONDARY INSURANCE COMPANY:		POLICY # / ID #:	GROUP #:
WORKER'S COMP/NO FAULT CLAIM INFORMATION (Complete, Only If Applicable)			
WORKER'S COMP/NO FAULT INSURANCE CARRIER: (Name, Address, City, State, & Zip)			
Claim/Case #:	Carrier Contact Name:		Carrier Telephone #:
Place of Employment Where Injury Occurred: (Company Name & Address)			Has Employer Been Informed of Work Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I hereby authorize and instruct my insurance carrier to pay Peak Performance Physical Therapy, PLLC directly for any physical therapy services. I understand I am responsible for payment of all co-pays, deductibles, and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services rendered to me. If I am the legal guardian of the patient named above, I accept responsibility for the above as well. I authorize the release of medical records to my insurance carrier and to Peak Performance Physical Therapy, PLLC.</p> <p>I hereby acknowledge that I have been informed that Peak Performance practices HIPAA and I am able to obtain a copy of Peak Performance Physical Therapy's "HIPAA NOTICE OF PRIVACY PRACTICES" upon request.</p>			
PATIENT'S SIGNATURE: (Parent If Patient Is Under 18)			DATE: