PEAK PERFORMANCE PHYSICAL THERAPY

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

NAME: (Last Name, First Name, Middle Initial)	Sex: ☐ Male ☐ Female	Social Security Number:

Address: (Street / Apt #, City, State, Zip Code)	Date of Birth:	Status: ☐ Married ☐ Student ☐ Single ☐ Other

Email Address:	Telephone # **(Primary)**: ☐ Cell ☐ Home	Telephone #: ☐ Cell ☐ Home	Text Appt. Reminders: ☐ Yes ☐ No

Name of Employer:	Telephone # (Work):

How Did You Hear About Us?

Name of Referring Physician:	Name of Primary Physician:

Is Your Visit Related To A Recent Surgery? ☐ Yes ☐ No Surgery Date:	Is This Due To A Worker's Comp Claim? ☐ Yes ☐ No Date of Injury:	Is This Due To A Motor Vehicle Accident/Claim? ☐ Yes ☐ No Date of Accident:

Have You Had Physical Therapy Before? ☐ Yes ☐ No	Are You Currently Receiving Medicare In-Home Health Care Services? ☐ Yes ☐ No

If Answered 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: ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ 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? ☐ Yes ☐ No

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.**

I hereby acknowledge that I have been informed that Peak Performance practices HIPPA and I am able to obtain a copy of Peak Performance Physical Therapy's "**HIPAA NOTICE OF PRIVACY PRACTICES**" upon request.

PATIENT'S SIGNATURE: (Parent If Patient Is Under 18)	**DATE:**