HERMITAGE ORTHOPEDICS AND SPORTS MEDICINE / PEAK PERFORMANCE PHYSICAL THERAPY

PATIENT INFORMATION

NAME	ADDRESS/CITY/STATE/ZIP	S.S.#

HOME PHONE	CELL PHONE	BIRTH DATE	AGE	SEX	MARITAL STATUS

REFERRING PHYSICIAN	ADDRESS/CITY/STATE/ZIP	PHONE

PATIENT'S EMPLOYER	ADDRESS/PHONE

HOSPITAL PREFERENCE: ☐ SHARON REGIONAL HEALTH SYSTEM ☐ UPMC ☐ EDGEWOOD SURGICAL HOSPITAL

SUBSCRIBER/GUARANTOR INFORMATION

NAME	ADDRESS/CITY/STATE/ZIP	S.S.#

HOME PHONE	CELL PHONE	BIRTH DATE	RELATIONSHIP TO PATIENT

SUBSCRIBER EMPLOYER	ADDRESS/PHONE

INSURANCE INFORMATION

PRIMARY INS COMPANY
ADDRESS

PHONE #:
GROUP #:
POLICY #:
CLAM #:

INS COMPANY 2
POLICY #:
GROUP #:
OTHER:

INS COMPANY 3
POLICY #:
GROUP #:
OTHER:

FAMILY PHYSICIAN/PRIMARY CARE PHYSICIAN ADDRESS/PHONE:

ARE YOU UNABLE TO WORK? ☐ YES ☐ NO IF SO, DATE LAST WORKED:

NEAREST RELATIVE (other than your address) THAT WE CAN CONTACT

Name____________________

Address____________________

Phone____________________

Relationship____________________

CONSENT TO MEDICAL TREATMENT

I consent to the performance and procedures which a HOSM/PPPT provider considers necessary or advisable in the course of my medical treatment.

Signature____________________

Was this the result of an accident? ☐ Yes ☐ No

Date of Injury ____________________

Work related: ☐ Yes ☐ No

Other ☐ Yes ☐ No

Describe injury briefly____________________

Do you have an attorney ☐ Yes ☐ No

Attorney name:

Phone #:____________________

How did you hear about us?

☐ Yellow Pages ☐ Newspaper Ad ☐ Hospital Referral Service ☐ Family Member ☐ Physician ☐ Friend ☐ Primary Care Physician
☐ Other ____________________

Referred by____________________

Address____________________

HERMITAGE ORTHOPEDICS AND SPORTS MEDICINE / PEAK PERFORMANCE PHYSICAL THERAPY

Consent for Treatment

I consent to the performance and procedures which Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy consider necessary or advisable in the course of my medical treatment.

Signature____ Date______________________

Medicare/MediGap

I request that payment of authorized Medicare/MediGap benefits be made directly to Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature____ Date______________________

Worker's Compensation

I authorize that payment on my behalf be made directly to Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy. I agree to pay Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy for any charges that are denied by the Worker's Compensation insurance carrier.

Signature____ Date______________________

All Other Insurance

I authorize that payment on my behalf be made directly to Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy for all charges that are not covered by my insurance company.

Signature____ Date______________________

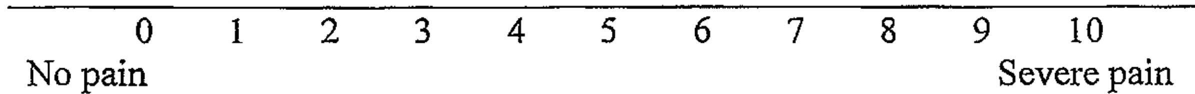
Self Pay

I agree to pay for all charges incurred during my care with Hermitage Orthopedics and Sports Medicine/Peak Performance Physical Therapy. I understand a payment is due with my first visit and a payment schedule will be arranged for all other charges.

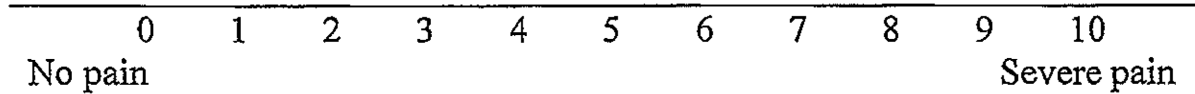
Signature____ Date______________________

The above signed authorizations are to be considered valid as long as I am under the care of a Hermitage Orthopedic and Sports Medicine/Peak Performance Physical Therapy provider, unless revoked by written request.

Please indicate your pain level at rest

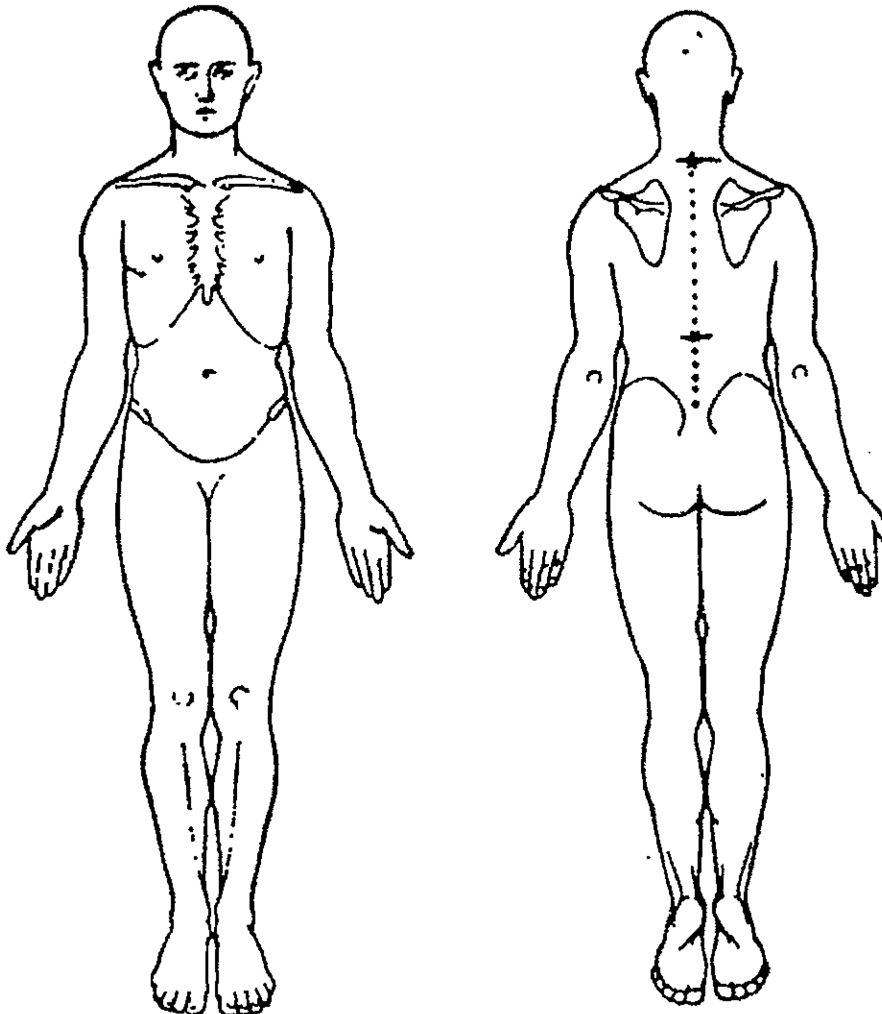


Please indicate your pain level with movement



Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

/// Stabbing	XXX Burning	OOO Pins & Needles	=== Numbness



Therapist's signature reviewing content: ______________________ Date: ______________

PAIN SCALE

SCALE	DESCRIPTION
0	None
1	Very, very minimal, can function normally
2	Very minimal; easily ignored, don't notice pain unless you think about the pain
3	Minimal, can be ignored
4	Mild; pain does not interfere with any activities; can sometimes forget about the pain when thinking about something else
5	Moderate; can continue activity; unable to forget about the pain
6	Moderate-severe; can continue activity but need to slow down; always aware of the pain
7	Severe; can continue activity but need to take a break once in a while
8	Very severe; can continue some activity but need to take a break often
9	Very, very severe; unable to continue any physical activity; need to lay down/rest
10	Hospital - Emergency Room because pain is unbearable

PEAK PERFORMANCE PHYSICAL THERAPY

"Journey to Wellness Begins Here"

HEALTH HISTORY QUESTIONS

Please answer the questions concerning your health status. All information is confidential.

NAME:________________________ AGE:________ DATE:______________

HEIGHT:______________ WEIGHT:______________ BLOOD PRESSURE:______________

OPERATIONS — **DATE**

____

____

____

____

____

____

____

CURRENT MEDICATIONS ☐ None

Drug — Strength — How Often?

____

____

____

____

____

____

____

MEDICAL ILLNESSES

(ie, Diabetes, High Blood Pressure, Heart, Lungs Kidneys, Cancer, Thyroid, etc.)

____

____

____

____

____

____

ALLERGIES TO MEDICATIONS ☐ None

Medications — Reaction

____

____

____

____

____

____

HEALTH HABITS

(Please answer each question)

Yes No

☐ ☐ Smoke Cigarettes? ____packs per day

☐ ☐ Drink Beer? ____bottles per ______

☐ ☐ Drink Hard Liquor? ____per_____

☐ ☐ Drink Wine? ____per______

☐ ☐ Do you exercise less than twice a week?

Yes No

☐ ☐ Chew Tobacco? _____how much

☐ ☐ Drink Regular Coffee? _____if so, cups/day?

☐ ☐ Use Aspirin or Ibuprofen? _____how often?

☐ ☐ On a Special Diet? _____what type?

☐ ☐ Have a Living Will?

FAMILY HEALTH HISTORY

Do these problems run in your family? (Please mark an "X" in the space provided below that applies to your family history)

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Other
Diabetes									
Heart Disease									
High Blood Pressure									
Stroke									
Cancer									
Gallbladder									
Colitis / Crohn's									
Respiratory									
Blood Disease									
Bleeding Disorders									
Other									

Review of Systems

Please mark "Yes" or "No" in the box

General

Yes	No	
☐	☐	Fainting
☐	☐	Unexpected Weight Loss
☐	☐	Recent Weight Gain
☐	☐	Fever or Shaking Chills
☐	☐	Night Sweats
☐	☐	Swollen Glands
☐	☐	Other________________

Skin

Yes	No	
☐	☐	Severe Itching
☐	☐	Persistent Rash
☐	☐	Changing Moles
☐	☐	Psoriasis
☐	☐	Other________________

Head

Yes	No	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Severe Headaches
☐	☐	Double Vision
☐	☐	Difficulty Hearing
☐	☐	Ringing in Ears
☐	☐	Wearing Hearing Aids
☐	☐	Wearing Dentures
☐	☐	Loose Teeth
☐	☐	Removable Bridge
☐	☐	Bleeding Gums
☐	☐	Severe Nosebleeds
☐	☐	Frequent Sore Throats
☐	☐	Persistent Hoarseness
☐	☐	Other________________

Blood

Yes	No	
☐	☐	Blood Transfusion Past 6 months
☐	☐	Prolonged Bleeding from Surgery
☐	☐	Anemia in Past
☐	☐	Ever Treated for Cancer
☐	☐	Think I'm High Risk for AIDS
☐	☐	Coumadin Use
☐	☐	Other________________

Muscle and Joints

Yes	No	
☐	☐	Muscle Cramps
☐	☐	Muscle Weakness
☐	☐	Arthritis or Joint Pain
☐	☐	Frequent Back Pain

Heart and Lungs

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Heart Attack in Past
☐	☐	Heart Murmur
☐	☐	Mitral Valve Prolapse
☐	☐	Artificial Valve
☐	☐	Rheumatoid Fever as a Child
☐	☐	Heart Disease
☐	☐	High Cholesterol
☐	☐	Fainting Spells
☐	☐	Irregular Heartbeat
☐	☐	Wear Pacemaker
☐	☐	Chest Pain
☐	☐	Shortness of Breath
☐	☐	Can't Breathe When Flat
☐	☐	Awaken Short of Breath
☐	☐	Ankles Swell
☐	☐	Frequent Cough
☐	☐	Cough up Sputum
☐	☐	Cough up Blood
☐	☐	Wheezing or Asthma
☐	☐	Other________________

Neurological

Yes	No	
☐	☐	Epilepsy or Seizures
☐	☐	Past Stroke
☐	☐	Other________________

Digestive Tract

Yes	No	
☐	☐	Hiatal Hernia in Past
☐	☐	Ulcers in Past
☐	☐	Colon Polyps in Past
☐	☐	Colon Cancer in Past
☐	☐	Liver Disease or Jaundice
☐	☐	Poor Appetite
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Frequent Heartburn
☐	☐	Heartburn Awakens
☐	☐	Trouble Swallowing
☐	☐	Rectal Bleeding
☐	☐	Black Bowel Movements
☐	☐	Vomited Blood
☐	☐	Abdominal Pain
☐	☐	Diarrhea
☐	☐	Lost Bowel Control or Soiling
☐	☐	Constipation
☐	☐	Bowel Habit Unpredictable
☐	☐	Milk or Lactose Intolerance
☐	☐	Gallstones
☐	☐	Other________________

Kidneys

Yes	No	
☐	☐	Kidney Stones
☐	☐	Kidney Disease
☐	☐	Frequent Urination
☐	☐	Up Nights to Urinate
☐	☐	Blood in Urine
☐	☐	Painful Urination
☐	☐	Slow Urination
☐	☐	Leakage of Urine
☐	☐	Other________________

Emotions

Yes	No	
☐	☐	Often Depressed
☐	☐	Cry Easily
☐	☐	Overly Anxious
☐	☐	Can't Handle Stress
☐	☐	Other________________

Exposure to

Yes	No	
☐	☐	TB
☐	☐	Rheumatic Fever
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Measles
☐	☐	Mumps
☐	☐	Chicken Pox
☐	☐	Whooping Cough
☐	☐	Contagious Disease
☐	☐	Other________________

Men Only

Yes	No	
☐	☐	Lump in Testicles
☐	☐	Penis Discharge
☐	☐	Erection Difficulties
☐	☐	Other________________

Women Only

Yes	No	
☐	☐	Pregnant Now
☐	☐	Planning Pregnancy
☐	☐	Nipple Discharge
☐	☐	Lump in Breast
☐	☐	Vaginal Discharge
☐	☐	Hot Flashes
☐	☐	Non-period Bleeding
☐	☐	Past Menopause
☐	☐	Painful Intercourse
☐	☐	Painful Periods
☐	☐	Change of Periods
☐	☐	Past Endometriosis
☐	☐	Other________________

Signature:________________________________ Date:________________________

PEAK PERFORMANCE PHYSICAL THERAPY

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing this form, you are granting consent to *Peak Performance Physical Therapy* to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our *Notice of Privacy Practices* provides information about the way we may use and disclose this protected health information. You have a legal right to review our *Notice of Privacy Practices* before you sign this consent, and we encourage you to do so. We reserve the right to amend our *Notice of Privacy Practices* for all protected health information including information obtained prior to the effective date of the amendment. You may obtain the revised *Notice of Privacy Practices* by submitting a written request.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

In addition to the aforementioned, this is to certify that I, the undersigned hereby consent to and authorize the disclosure of any medical information to the following people:

______________________________ Relationship: ______________________

______________________________ Relationship: ______________________

______________________________ Relationship: ______________________

______________________________ Relationship: ______________________

May we call your cell phone? Yes ☐ No ☐ If yes, cell phone #:______________________

May we leave messages on your answering machine or cell phone? Yes ☐ No ☐

May you be called at your place of employment to be informed of your appointment or medical information?

Yes ☐ No ☐ If yes, phone number: ______________________

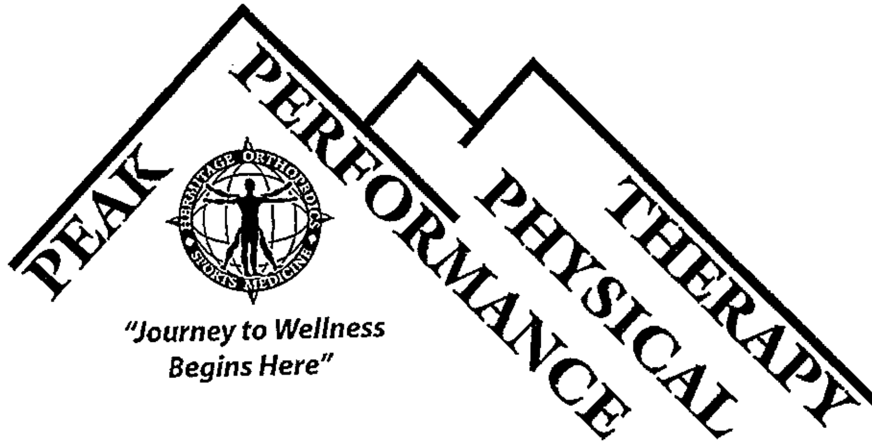
I consent to receive automated calls or text messages from PPPT for my protected healthcare and other services at the phone numbers listed on my record, including any wireless number provided. I understand I may be charged for such calls by my wireless carrier based on my calling plan. Yes ☐ No ☐

If you do not want certain disclosure made to the above or to other individuals, it is your responsibility to notify our office in writing.

Questions regarding the content of this form have been satisfactorily explained to me and I certify that I understand its contents.

Patient/Parent/Guardian name: ______________________________ Date: ______________

Witness: ______________________________________ Date: ______________



Peak Performance Physical Therapy Attendance Policy

Peak Performance Physical Therapy will strive to provide you with the best physical therapy care because we believe you deserve the best. We also understand that your time is valuable.

Thus, we request the following:

- In order for us to provide you with optimal care, we ask that you allow a minimal of one (1) hour for your appointments and arrive promptly at your scheduled time.
- Although we will make every effort to accommodate you, a late arrival of 15 minutes or more, may need to be rescheduled for another date.
- We also ask that you call as early as possible if you need to cancel your appointment. ***If you do not show for a scheduled appointment three (3) times, you will need to contact your physician's office for further recommendations regarding your physical therapy.***

We hope you understand that these guidelines allow us to provide you with focused and uncompromised service. You deserve nothing less!

Sincerely,

Peak Performance Physical Therapy

1005 Campus Circle * Hermitage, PA 16148 * Phone: 724-346-1529 * Fax: 724-346-1498

Financial Policy

Hermitage Orthopedics and Sports Medicine and Peak Performance Physical Therapy are dedicated to providing the best possible care and we want you to be informed about and understand our financial policy.

1. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign benefits to the doctor. This indicates that you agree to have your insurance company pay the doctor directly.

2. We have made prior arrangements with most insurance companies and most health plans to accept assignment of benefits. We will bill them directly for our services. If your contract has a copayment, you are required to pay the copayment at the time of your visit.

3. Not all insurance plans cover all services. In the event your insurance plan determines a service is "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office, unless payment arrangements are made in advance.

4. We will bill your insurance company for services provided by Hermitage Orthopedics and Sports Medicine and Peak Performance Physical Therapy. You are responsible for any balance due.

   I have read and understand the practice's financial policy and I agree to be bounds by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_______________________________________ _______________________

Signature of patient (or responsible party, if minor) Date

____

Please print the name of the patient

Peak Performance Physical Therapy Co-Payment Policy

Due to changing insurance plans, we have had to implement a policy for collecting co-pays.

Your co-pay is a contractual agreement with your insurance company that you are required to pay, and we are obligated to collect.

Since your therapy visits are 2-3 times a week, you have the option of paying per visit or on a weekly basis.

In addition to your co-pay, your insurance may have an annual deductible. If you do have a deductible which is applied to any of your services here, we will bill you for the balance.

Please notify the front desk which option you choose for paying your co-pay, per visit or weekly.

Sincerely,

Peak Performance Physical Therapy

1005 Campus Circle • Hermitage, PA 16148 • Phone: 724-346-1529 • Fax: 724-346-1498