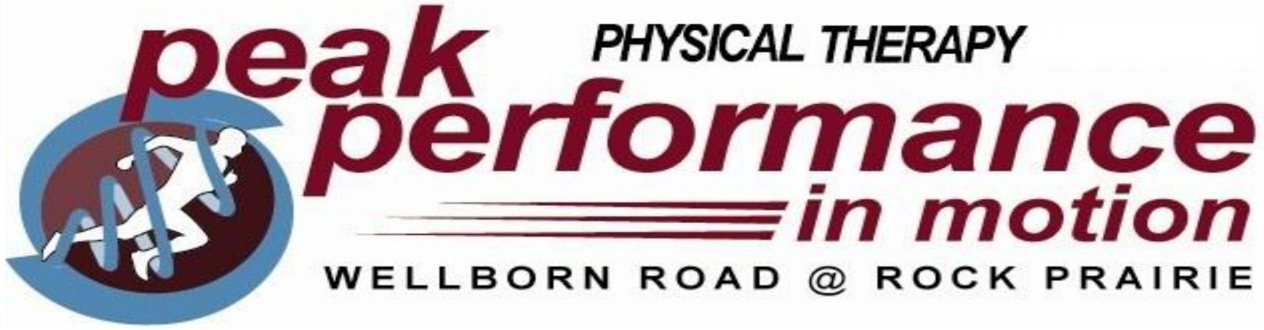

Last name_____________________________________ First name______________________________________ Middle___________

Social Security_________________________________ DOB____________________________ Sex: MALE FEMALE

Mailing Address____ City__________________________ State_______ Zip________

Permanent Address____ City__________________________ State_______ Zip_________

Home number_________________________ Cell number_______________________ Primary Contact: HOME CELL WORK EMAIL

Email address____ Spouse Name____________________ Contact Number______________________

Nearest Relative (Not Living With You)________________________________ Relationship__________________ Contact Number________________________

Have you had any imaging done for this injury? YES NO If yes, what type? MRI CT Scan X-RAY OTHER______________________________

Where was this imaging done? ____ Referring Doctor____

How did you hear about us? ____

Why are you coming to therapy? (Circle all that apply) PAIN INJURY ACCIDENT SURGERY OTHER________________________________

Date of injury, accident, surgery_____________________________ When did pain begin?____

Describe incident____

ATTENTION ALL MEDICARE PATIENTS – EFFECTIVE JANUARY 1, 2018

Beginning January 1, 2018, Physical and Speech therapy services received in any of the following settings will be subject to the combined $2010.00 calendar year cap: Part B Skilled Nursing Facilities (SNF's), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Rehabilitation Facilities (ORFs), private practices, home health agencies, and hospital outpatient departments. Initial_________

Have you received any physical or speech therapy this year? YES NO If yes, where?_________________________ How many sessions?_______

Release of information: I understand that as part of my healthcare, Peak Performance in Motion originates and maintains medical records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as a means of communication among the many health care providers who contribute to my care, and as a means by which a payer can verify that services billed were actually provided. I hereby authorize Peak Performance in Motion and any of its employees to furnish to my insurance or third party payer any and all information necessary to process my claims. Initial_______

Assignment of Benefits: I assign and transfer all rights and benefits payable for healthcare rendered to Peak Performance in Motion. A photocopy of this assignment shall be considered as valid and effective as the original.. Initial_______

Consent of Treatment: I hereby consent to and authorize Peak Performance in Motion and its staff to administer any and all treatment as per my physician's orders. Initial________

I have read and fully understand this document. I attest that the above said information in valid and true. I have signed this document freely and without coercion.

Patient Signature:_______________________________________ Date:_________________________