



***Peak Performance Therapy, P.C.
Patient Information Sheet***

Today's Date: _____

Check One: Workman's Compensation Medicare Private Ins. Self Pay

Name: _____ S.S. #: _____

Last First Initial

Primary Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Ph: _____ Secondary Ph: _____ Cell: _____

Secondary Address (If applicable): _____

City: _____ State: _____ Zip: _____

Primary Ph: _____ Secondary Ph: _____ Cell: _____

Email Address: _____

Sex: M F Age: _____ Birth date: _____ Single Married

Employer: _____ Referred by (if not a doctor): _____

Emergency Contact & Phone Number (include how related): _____

PRIMARY INSURANCE INFORMATION HOLDER

Person Responsible for Account:

Name: _____ S.S. #: _____

Last First Initial

Relation to Patient: _____ Birth date: _____

Address (If different from patient's): _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

INSURANCE INFORMATION (make copy of card or information)

Insurance Company: _____

Phone #: _____ Group #: _____ Policy #: _____

WORKMAN'S COMP INFORMATION

W/C #: _____ Date of Injury: _____ Ref. Dr.: _____

OFFICE USE ONLY

Date of Injury: _____ Ref. Dr.: _____

Diagnosis _____ Dx Code _____

Car Accident Yes No State of Accident: _____ Auto Ins. Phone: _____

IMPORTANT—PLEASE READ CANCELLATION POLICY (Please Initial Below):

_____ You must give a 24 HOUR NOTICE if you cannot make your appointment.

A FEE OF \$50 WILL BE CHARGED TO YOU for any appointments missed without proper notice.



Peak Performance Therapy, P.C.

PRIVACY NOTICE

I have read and understand the Peak Performance Therapy Privacy Policy (copies are available at the Peak Performance office in Telluride). I have been offered a copy for my own records.

Date _____

Signature of Patient or Guardian
If Patient is under 18 years of age

Date _____

Witness (to signature only)



PATIENT CONSENT AND AUTHORIZATION

A: PATIENT CONSENT FOR TREATMENT

I hereby request and authorize Peak Performance Therapy, PC (“PPT”) and whomever PPT may designate to perform a physical therapy evaluation and treatment. I authorize and give consent to my therapist and his/her designees and assistants to perform any procedures they feel are needed and necessary. I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guaranties have been, or can be made, regarding the likelihood of success or outcome of any therapy.

RISKS: I have advised the therapist of any pre-existing health conditions or recent health changes.

PATIENT’S CONSENT: I have read and fully understand this consent form, and I understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED THERAPY TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED THERAPY TREATMENT, PLEASE ASK YOUR THERAPIST BEFORE SIGNING THIS CONSENT FORM.

B: AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information when applicable to process third party claims. I allow authorized third party payers to pay medical benefits directly to Peak Performance Therapy, PC.

C: PAYMENT AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account in accordance with the regular rates and terms of this practice. Should the account be referred to an attorney or agency for collection, the undersigned shall pay reasonable attorney’s fees and collection expenses up to 100% of your account balance. All delinquent accounts bear interest at the legal rate.

PAYMENT IS DUE AT THE TIME OF TREATMENT.

I HAVE READ AND ACCEPT THE CONDITIONS OF CONSENT.

Signature of Patient or Parent/Guardian
If Patient is under 18 years of age

Date: _____

Witness (to signature only)

Date: _____

THERAPIST DECLARATION: I have explained the therapy, alternatives, benefits, and risks to the patient and have answered all the patient’s questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

Therapist’s Signature

Date: _____



ASSIGNMENT OF BENEFITS

Patient: _____

Date of Birth: _____

Social Security Number: _____

Claim/Group/Policy No.: _____

I hereby instruct and direct ("Insurance Company") _____
to pay by check made out and mailed to:

**PEAK PERFORMANCE THERAPY, PC
P.O. BOX 3178
TELLURIDE, CO 81435**

I, the undersigned, give permission to Peak Performance Therapy, PC to release information to Insurance Company and/or any third party insurance carrier, adjuster, or attorney involved in this case and I give all my rights and benefits under the above-referenced policy and request that this Assignment of Benefits remain on file with my Insurance Company. The assignment will not exceed my indebtedness to the above-mentioned assignee.

I hereby agree to pay in a current and timely manner any balance of Peak Performance Therapy, PC's professional service charges over and above the insurance payment(s).

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case.

Signature of Patient

Date: _____

Signature of Parent/Guardian
(If patient is under 18 years of age.)

Date: _____

Witness Signature

Date: _____