Patient Information

☐ Drop Box Patient # _____ ☐ Walk-In

Initial Call Date: _____ Previous Patient: ☐ No ☐ Yes, When _____ Clinic: _____

Appointment Day/Date: _____ Appointment Time: _____ Therapist: _____

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Name you wish to be called or Nickname

Gender ☐ Male ☐ Female	Date of Birth	Language Preference: ☐ English ☐ Spanish ☐ French ☐ Other	Student Status: ☐ Not a Student ☐ Full-Time ☐ Part-Time

Marital Status ☐ Single ☐ Married ☐ Unknown ☐ Other, _____	☐ Employed ☐Self-Employed ☐ Not Employed ☐ Retired ☐ Student Employer Name:

In the case of a minor, what are the parent's/legal guardian's names: ☐ **PATIENT IS NOT A MINOR**

Mother: _____ Father: _____ Legal Guardian: _____

Home Address:	City	State	Zip

Other Address: ☐ Parents ☐ Mailing ☐ Other, _____	City	State	Zip

Preferred Phone Number: ☐ Home ☐ Mobile ☐ Other	May we leave a message on your recorder/voicemail? ☐ Detailed Message ☐ No Message	Alternate Phone Number (*Optional*) ☐ Home ☐ Mobile ☐ Other	May we leave a message on your recorder/voicemail? ☐ Detailed Message ☐ No Message

Emergency Contact Name: ☐ Declined	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other:	Phone Number: ☐ Home ☐ Mobile ☐ Other	May we leave a message on your recorder/voicemail? ☐ Detailed Message ☐ No Message

To improve our communication with you, may we have your email? **PLEASE USE CAPITAL LETTERS** ☐ Declined	Would you like to receive appointment reminders through? ☐ Email ☐ Text ☐ Declined

When do you return to the doctor?	Patient, please sign here if the above information is complete and correct: X_____ Date: _____

CASE INFORMATION – OFFICE SECTION ONLY

☐ Left ☐ Right ☐ Bilateral ☐ Not Applicable **Body Part:**	Cause of Injury ☐ Employment ☐ Auto Accident/Third Party Liability ☐ None of the above

Referring Physician	Date of Last Physician Visit	Date of Injury	Date of Surgery	State Injury Occurred *Work Comp Only*

Intake completed by: Date:	Reviewed/Entered by: Date:

Eligibility/Benefits Summary

Patient Name:	Patient Date of Birth:

PRIMARY INSURANCE

Name of Insurance Provider:	Member ID/Policy #
Claim's PO Box Address:	Insurance Plan Phone Number:

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other, _____

Subscriber's Name if Different from Patient:	Subscriber's Date of Birth if Different from Patient:

Subscriber's Address if Different from Patient:

Insurance Representative	Call Reference #:	☐ Website/Fax Verified

☐ Calendar Year Plan ☐ Policy Year Plan _____ Policy Effective Date: _____

Individual Ded: **$** _____ Met: **$** _____ Individual OOPM: **$**_____ Met: **$** _____

Copay: ☐ Yes ☐ No Amount: **$**_____ Co-Insurance: ☐ Yes ☐ No Percentage: _____ **%**

Visit Limit: ☐ Visits based on Medical Necessity ☐ Visits Limited to _____ ☐ CY ☐ PY Used: _____

HRA/HSA Policy: ☐ Yes ☐ No
If yes, does the patient have a HRA/HSA credit card?: ☐ Yes ☐ No

Authorization/Referral Required? ☐ Auth ☐ PCP Ref ☐ N/A
Source: _____

Special Insurance Agreements: ☐ Carpenters Direct Billed ☐ Midway USA ☐ Other

SECONDARY INSURANCE ☐ **No Secondary**

Name of Insurance Provider:	Member ID/Policy #
"Mail Medical Claims To" PO Box:	Insurance Plan Phone Number:

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other, _____

Subscriber's Name if Different from Patient:	Subscriber's Date of Birth if Different from Patient:

Subscriber's Address if Different from Patient:

Insurance Representative	Call Reference #:	☐ Website/Fax Verified

Individual Ded: **$** _____ Met: **$** _____

Copay: ☐ Yes ☐ No Amount: **$**_____

Medicare Therapy Thresholds ☐ Not Applicable Used: OT **$** _____ PT/SLP **$** _____

Medicare Replacement Plan ☐ Yes ☐ No

Benefit Summary:

As a courtesy to you, our patient, we obtained the following benefits/eligibility information from your insurance carrier. IT IS VERY IMPORTANT TO NOTE this is not a guarantee of benefits and the benefit/eligibility information may change when your insurance provider processes our claims.

☐ According to the benefits obtained, your per visit responsibility is $_____ ☐ Towards your Deductible. ☐ Copay.
This amount is due at the time of each service. If your insurance provider assigns additional patient responsibility, you will be sent a statement.

☐ Based on the benefits obtained, CMPT will bill your insurance company and any patient responsibility assigned will be billed to you on a patient statement.

Date Benefits Verified: Staff Initials:	Patient's Signature: _____ Date: _____ Staff Signature: _____ Date: _____

Patient Name:	Patient Date of Birth:

STATEMENT OF FINANCIAL RESPONSIBILITY

PEAK Sport and Spine appreciates you choosing us to be your partner in your rehabilitation. Physical and hand therapies may carry a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and upon receipt of a statement for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Patient Statement. Payments can be made at the facility you attended, mailed to the address on your statement, by phone at our Central Billing Office at 573-449-6082 or on-line at www.peaksportspine.com.

Financial Responsibility:

By signing below, I attest I understand that any balance remaining unpaid at the end of the repayment period may be referred to a collection agency and may be reported to the credit bureau as an unpaid debt. I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency fees, reasonable attorney fees and court costs). In the case of a returned check, there may be an additional $35.00 Returned Check Fee charge to my account.

I have read the above policy regarding my financial responsibility to Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine for providing rehabilitative services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine. I agree to pay Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Consent of Treatment and Authorization to Release Information

By signing below, I hereby authorize Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine through its appropriate personnel, to furnish medical care and treatment to me, or the above-named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

I further authorize Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine to release to appropriate agencies, any information acquired in the course of my or the above-named patient's examination and treatment necessary to secure payment for services provided.

Notice of Privacy and Disclosure of Personal Health Information:

I, the undersigned, do hereby acknowledge that I have received or have been made aware of Central Missouri Physical Therapy, LLC, dba PEAK Sport and Spine's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I authorize Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine to disclose my health information that is directly related to my current treatment at Central Missouri Physical Therapy, LLC dba PEAK Sport and Spine to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

_____ _____
Print Person's Name Relationship

☐ DO NOT RELEASE TO ANYONE

_____ _____
Print Person's Name Relationship

Cancellation/No Show Policy:

PEAK Sport and Spine makes every accommodation possible in the scheduling of our patients. We realize emergencies do arise forcing patients to cancel their appointment. We ask our patients to please give us 24-hour notice of cancelling an appointment whenever possible so that we may contact another patient who may be waiting for an appointment. In the event you fail to show for an appointment, or you cancel an appointment with less than 24-hour notice, **PEAK Sport and Spine reserves the right to charge you *$25.00.*** You will need to pay these fees at your next appointment prior to your treatment. These fees cannot be billed to your insurance provider as they are not for medical services rendered. They also may not be paid with an HSA or Flex Spending credit card as this fee is not for medical services. Emergencies involving our staff may also arise. We will make every attempt to reschedule your appointment for the same day but with another clinician. Unfortunately, we may be forced to reschedule your appointment to another day.

Please note that the information included in this *Statement of Financial Responsibility* form is subject to any applicable state laws, rules or regulations that impact your financial responsibility and whether there is an amount owed.

X_____ _____
Patient/Parent/Legal Guardian Signature Date

PEAK Sports and Spine Representative: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

PLEASE ANSWER ALL QUESTIONS BELOW

Do you have or have you ever had any of the following problems:

Y N

☐ ☐ **ASTHMA**

☐ ☐ **CARDIOVASCULAR CONDITIONS** (Angina, Congestive Heart Failure, Pacemaker/Defibrillator, Peripheral Vascular Disease)

☐ ☐ **Other Heart Problems**: *Explain* _____

☐ ☐ **High Blood Pressure**
Controlled by Medication? ☐ Yes ☐ No

☐ ☐ **COPD, ARDS or EMPHYSEMA**

☐ ☐ **ARTHRITIS**
Rheumatoid – Joints Affected _____
Osteoarthritis – Joints Affected _____

☐ ☐ **Back Pain** (neck, low back, Degenerative Disc Disease, Spinal Stenosis)

☐ ☐ **Broken Bones**

☐ ☐ **Osteoporosis**

☐ ☐ **Other Orthopedic Problems:** *Explain* _____
_____

☐ ☐ **Epilepsy or Seizure Disorders**

☐ ☐ **Stroke/TIA**, *When* _____

☐ ☐ **Traumatic Brain Injury**

☐ ☐ **Head Injuries:** Accident, Concussion, Headaches, Fainting

☐ ☐ **Multiple Sclerosis**

☐ ☐ **Parkinson's Disease**

Y N

☐ ☐ **Other Neurological Conditions:** *Explain* _____
_____

☐ ☐ **AIDS/HIV**

☐ ☐ **Cancer**, *What Type:* _____

☐ ☐ **Mental Health Issues** *Explain* _____
_____

☐ ☐ **Diabetes** ☐ Type 1 OR ☐ Type 2

☐ ☐ **Dizziness**

☐ ☐ **Eating Disorders**

☐ ☐ **Gastrointestinal Disease** (ulcer, hernia, reflux, bowel, liver, gallbladder)

☐ ☐ **Hearing Impairment**

☐ ☐ **Hepatitis** ☐ Type A ☐ Type B ☐ Type C

☐ ☐ **History of Falls**

☐ ☐ **Incontinence**

☐ ☐ **Kidney, Bladder, Prostate or Urination Problems**

☐ ☐ **Pregnant** (currently)

☐ ☐ **Previous Auto Accident Resulting in Injury to You**

☐ ☐ **Prosthesis/Implants**

☐ ☐ **Tuberculosis**

☐ ☐ **Visual Impairments**

☐ ☐ **Pneumonia**

☐ ☐ **Other Problems:** *Explain* _____

Have you been diagnosed with the COVID-19 Virus? ☐ Yes ☐ No

If you were diagnosed with the COVID-19 Virus, were you hospitalized? ☐ Yes ☐ No

If you were diagnosed with the COVID-19 Virus, do you suffer any effects of the virus? ☐ Yes ☐ No

If yes, what effects: _____
_____

Please describe your use of:

Tobacco ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

Alcohol ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

Daily Caffeine Usage ☐ None ☐ 1-2 cups/day ☐ 2-3 cups/day ☐ 3-4 cups/day ☐ 4 or more cups/day

How often do you exercise?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

Do you have any allergies to medications, adhesives, or other items? ☐ No ☐ Yes, please list: _____
_____

Please list any medications you are now taking both prescriptions and over the counter or provide us with a separate list.

Medication	Dosage (i.e. number of mg.)	Frequency of Medication	Taken Orally/by Injection

Patient/Parent/Guardian Initials: _____ Date: _____ Therapist's Initials:_____

Patient's Name: _____ Date of Birth: _____

PLEASE ANSWER ALL QUESTIONS BELOW

Current Condition

When did your current condition/injury begin? _____

Briefly describe how the injury occurred:

_____

_____

Do you have recent x-rays, MRIs, or tests for your current condition/Injury? ☐ NO ☐ Yes, *Explain* _____

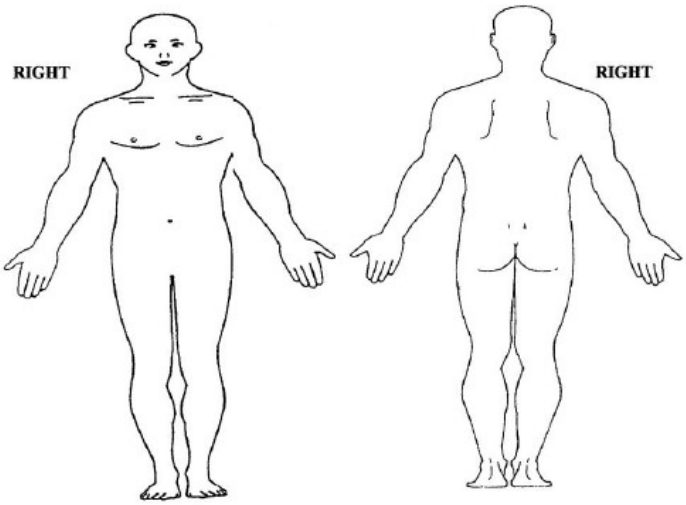
_____

Have you had therapy/Chiropractor care for this condition within the past 6 months? ☐ NO ☐ Yes, How Many Visits? _____

Please list any surgeries or injections pertaining to your current condition/injury:

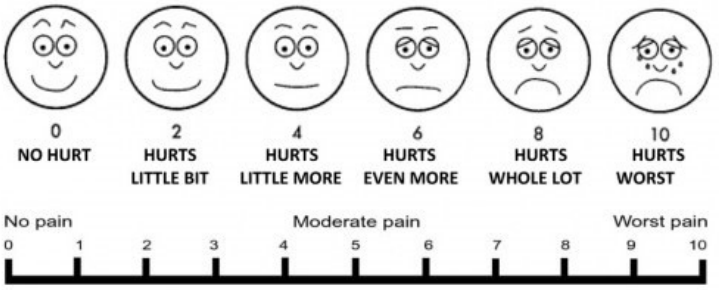
Date (Approx.)	Surgery/Hospitalization	Reason

Please indicate on the drawing below where you are having pain and what type of pain are you having.



FRONT **BACK**

Please indicate the areas of pain and discomfort (on the figures above) using the following symbols:
/// - Pain
*** - Numbness, no feeling at all
+++ - Tingling, asleep, or abnormal feeling



Indicate your **CURRENT** pain level on the bar above or circling a face.

What is your current pain level? _____/10

What is your pain level at its WORST? _____/10

What is your pain level at its BEST? _____/10

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

By signing this, the therapist attests he/she has reviewed this with the patient.