



Important Information Regarding your Medical Insurance

A representative from Peak Motion Physical Therapy has called your insurance company to attempt to obtain your benefit information and any necessary authorizations. Benefit information that is quoted to our representative by your insurance company is not a guarantee of payment. We are under contractual obligation with your insurance company to collect any anticipated co-payments, deductibles, and/or coinsurance amounts at each visit. Payments you make to our office will be applied to your account, and you will be billed for any remaining balance after we have received all expected payments from your insurance company. If you have overpaid, credits will be refunded within thirty days of receiving all anticipated insurance payments. We will file to any applicable secondary insurance companies as a courtesy. We recommend contacting your insurance company or referring to your insurance handbook if you have any questions regarding your physical therapy benefits.

Helpful terms

Co-payment: A payment made by an individual who has health insurance, usually at the time a service is received, to offset some of the cost of care. Usually a set amount such as \$20, \$30, or \$40, and will need to be paid at each visit.

Coinsurance: A provision by which the insured individual shares in the cost of certain expenses. In these instances, the insurance pays a percentage of the allowed charges (e.g. 80%), and the patient pays the remaining percentage (e.g. 20%). We will collect \$20 at each appointment and you will be billed for any remaining balance at the end of your care.

Deductible: The portion of any claim that is not covered by the insurance provider. It is the amount of expenses that must be paid out of pocket to the provider's office before an insurer will cover any expenses. We will collect \$100 at each visit until your deductible has been met. However, your charges may exceed the amount that we collect, and you will be billed for any additional amount that your insurance deems as "patient responsibility". Co-payment or coinsurance rules may take affect after your deductible has been met.

I have read and understand the above information.

Patient/Responsible Party Signature: _____



PEAK MOTION
PHYSICAL THERAPY, INC.

PATIENT HEALTH HISTORY

Date: ___/___/___

Date of Injury: _____

❖ Patient Information

Patient Name: _____

Patient Age: _____ DOB: ___/___/___

Mechanism of Injury: _____

Emergency Contact: _____

Occupation: _____

Emergency Phone #: _____

❖ Patient History

How did the pain start?

- Suddenly
- Gradually
- Lifting
- No Reason
- Pulling
- Injured at work
- Bending
- Other: _____

What activities increase pain?

- Exercise (During)
- Exercise (After)
- Sitting
- Walking
- No Reason
- Bending forward
- Bending Backward
- Coughing
- Sneezing
- Other: _____

What activities reduce pain?

- Lying down
- Sitting
- Standing
- Walking
- Anti-Inflammatory
- Pain Pills
- Injection for pain
- Muscle Relaxants
- Nothing
- Other: _____

How long have you had this pain?

___ Years ___ Months ___ Weeks

Have you had any diagnostic tests?

- X-ray Date: _____
- CT Scan Date: _____
- EMG/NCV Date: _____
- MRI Date: _____
- Injections Date: _____

Have you had surgery for your problem?

List your Medication:

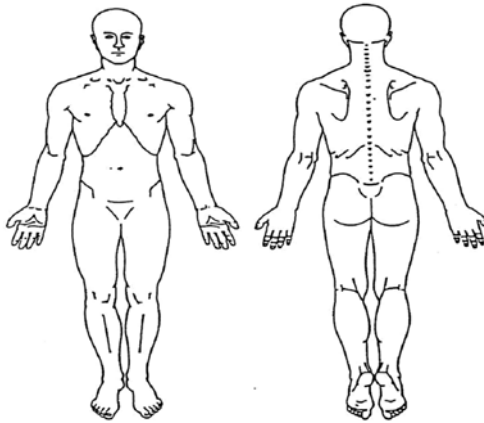
Yes / No : _____

Any Surgery: _____

Pain / Symptoms:

On the Body Diagram, indicate your region of pain using the symbols below.

(X) : Sharp (+) : Numb/Tingling (#) : Dull/Aching (B) : Burning



Rate your Pain:

Pain Level (0-10): _____

0=No Pain & 10= Emergency Room

Place a checkmark for **YES** & leave **BLANK** for **NO**.

- Allergies: _____
- Diabetes
- High Blood Pressure
- Heart Disease
- Stroke (CVA)
- Cancer : _____
- Pulmonary
- Arthritis (OA)
- Arthritis (RA)
- (Ir)Regular Headaches
- Dizziness/Blackouts
- Seizures
- Bowel/Bladder Issues
- Asthma/ Breathing Issues
- Pacemaker
- Heart Attack
- Hypoglycemia
- Osteoporosis
- Sexual Dysfunction
- Are you Pregnant?
- Hernia
- Kidney Problems
- Liver Problems
- Smoker
- Metal Implants: _____
- Other: _____

Patient Signature: _____ : Therapist Signature: _____



CLINIC POLICIES

Date: ____/____/____

❖ **WELCOME TO PEAK MOTION OUTPATIENT PHYSICAL THERAPY.** We are pleased you have chosen our service and we will do everything possible to optimize your satisfaction while you are here. Listed below are some policies and suggestions we have in place while you are receiving physical therapy. If you have any questions, concerns or comments, you may inquire with our front office staff to speak with the clinic manager or request to speak with the owner.

Sincerely,
Philip M. Baca

❖ Policies

ATTENDANCE- IF YOU ARE UNABLE TO ATTEND, YOU MUST NOTIFY THE CENTER IN ADVANCE AND RESCHEDULE TO MAKE THE MISSED APPOINTMENT.



- **If you cancel or fail to attend 3 consecutive appointments, it may result in termination of your therapy program.**
- A \$25 no-show/late cancellation charge will be applied to those who **do not** give 24 hours notice.
 - ✓ **Saturday** appointments must be cancelled prior to 9:00am Friday.
 - ✓ **Monday** appointments must be cancelled prior to 12:00pm Friday.
 - ✓ **Please be aware that insurance will not cover charges for no-shows/late cancellations.**
- **Worker's Compensation:** Your physician, employer, and insurance adjuster will be contacted.



MUSIC-At Peak Motion, music creates what we feel is an important role in setting a positive atmosphere for the clinic setting. In the gym, upbeat music is used to motivate and facilitate exercise. However, at any time, you find the music offensive or would like to request something, please ask any of our staff for a change.



GUESTS- Children and guests are encouraged to remain in the lobby, however, if there is a concern about the patient, please speak with our therapist. Please understand this policy is in place purely for the **safety** of your children or to decrease the traffic in the clinic. An adult in the waiting area must quietly supervise small children.

I have read and understood the above. I understand that attendance at each therapy session is important to my recovery and will notify my therapist if unable to attend a session so that it may be rescheduled.

Patient signature: _____ Date: ____/____/____

Parent Signature: _____ Date: ____/____/____
(If Minor)

Thank you in advance for you understanding and cooperation. We look forward to participating in your rehabilitation.



TREATMENT POLICY

❖ PAYMENT POLICY AND BILLING PROCEDURES

1. You are responsible for the co-pay, co-insurance and/or deductible not covered by your insurance company. Payment is required at the time of each visit. Peak Motion will NOT bill you for co-pays, co-insurance, and deductible.
2. Your estimated co-pay amount is \$ _____ per visits. Your estimated coinsurance amount is \$ _____ per visit. Your estimated deductible amount is \$ _____. Payment is due in full at the time of your visit.
3. You will receive a statement, which will show you the status of your account.
4. We accept Visa, MasterCard, and Discover bankcards.
5. There is a **\$40** charge for all returned checks.

❖ INSURANCE INFORMATION

As a courtesy to our patients, we will call your insurance company for benefit information, and we will file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations that limit the benefit in some way, such as sessions, supplies, deductibles, co-pays, etc. The stipulations should be noted in your policy manual.

❖ SUPPLIES POLICY

SUPPLIES: Payment for all supplies not covered by insurance is due at the time of service.

MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible to pay for all supplies used for your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

WORKER'S COMPENSATION benefits will be reviewed; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

MEDICAL RECORDS: Medical records will be provided within 30 days after the date of your request. If you require Medical records prior to 30 days, you will be billed a **\$40.00** convenience charge.

❖ CONSENT TO TREAT

I understand that I have been referred for rehabilitative treatment and care to Peak Motion Physical Therapy. Peak Motion will perform an Initial evaluation and then describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Peak Motion Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policies and billing procedures of Peak Motion Physical Therapy. I hereby authorize Peak motion Physical Therapy to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign Peak Motion Physical Therapy all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Outpatient Rehabilitation. It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Peak Motion Physical Therapy for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

❖ BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I, _____, authorize Peak Motion Physical Therapy, Inc., to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

❖ **HIPAA:** A copy of the Notice of Privacy Practices was provided to me by Peak Motion Physical Therapy, Inc. and I have read and understand the HIPAA Act. (Initials): _____

Print Name: _____

Signature: _____ Date: ____/____/____



PEAK MOTION PHYSICAL THERAPY, INC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Peak Motion Physical Therapy and each of its subsidiaries, affiliates, and entities managed or controlled by, Peak Motion Physical Therapy. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Peak Motion Physical Therapy. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to Peak Motion Physical Therapy, 7920 Carmel Ave suite #2 Albuquerque, NM 87122.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or healthcare operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Peak Motion Physical Therapy, 7920 Carmel Ave suite #2 Albuquerque, NM 87122.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information

You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You are entitled to one free copy of your personal health information. If you request additional copies you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information

You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to Peak Motion Physical Therapy, 7920 Carmel Ave suite #2 Albuquerque, NM 87122. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact Peak Motion Physical Therapy, 7920 Carmel Ave suite #2 Albuquerque, NM 87122 or 505-797-5505

Patient (or representative) Signature

Date