PEAK
Performance Therapy & Wellness

Certified Functional Manual Therapy

LAST NAME_____ FIRST NAME_____ MI_____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE _____ CELL PHONE_____

BUSINESS PHONE_____ EMAIL ADDRESS_____

DATE OF BIRTH_____ MARITAL STATUS SINGLE/MARRIED/OTHER SEX M/F

EMERGENCY CONTACT, LEGAL GUARDIAN _____ PHONE NUMBER _____

REASON FOR VISIT: INJURY/ACCIDENT/SURGERY/WELLNESS CONSULT

DATE OF INJURY/SURGERY _____

PLEASE BRIEFLY DESCRIBE YOUR INJURY_____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN_____

WHO CAN I THANK FOR THE REFERRAL?
_____

WHAT IS YOUR CURRENT FORM OF EXERCISE ?
_____

DO YOU CURRENTLY WORK WITH A PERSONAL TRAINER?
_____

WHAT IS YOUR GOAL WITH PHYSICAL THERAPY
_____

168 Boston Post Road, Madison, CT 06433 | [p] 203.421.2435 : [f] 203.421.6095 | brian@peakptw.com | peakptw.com

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Past Medical History Form

Have you currently or in the past had any issues with the following? If so, please circle and use the line to the right to elaborate with any pertinent details.

Y/N DETAILS

___ GENERAL (FEVER/CHILLS, NAUSEA/VOMMITING, UNEXPLAINED WEIGHT LOSS, FATIGUE)
_____

____ SKIN (RASHES, SKIN LESIONS, MOLE CHANGES) _____
____ EYES (BLURRED VISION, DOUBLE VISION, CHANGE IN VISUAL ACUITY)
_____
____ EARS (NASAL CONGESTION, DISCHARGE/ BLEEDING)
_____
____ NOSE (NASAL CONGESTION, DISCHARGE/BLEEDING) _____
_____
____ MOUTH (SORE THROAT, DIFFICULTY SWALLOWING) _____
_____
_____
____ BREATHING ( SHORTNESS OF BREATH, COUGHING, WEEZING) _____
_____
_____
____ HEART (HIGH OR LOW BLOOD PRESSURE, PALPITATIONS, INCREASED/DECREASED HR)
_____
_____
_____
____ GI (NAUSEA/VOMITTING, DIARRHEA, ABDOMINAL PAIN, CONSTIPATION, DISCOLORED STOOLS) _____
_____
___ GENITOURINARY (PROBLEMS WITH BLADDER, INITIATING OR CONTROLLING, FREQUENCY) _____
_____
___ ENDOCRINE (HEAT OR COLD INTOLERANCE, WEIGHT LOSS/GAIN, INCREASED THRIRST)
_____
_____

___ HEMATO-IMMUNOLOGIC (BRUISING EASILY, INTERNAL BLEEDING) _____
_____

___ PSYCHIATRIC (DEPRESSION, ANXIETY, SUICIDAL IDEATIONS, ATTEMPTS) _____
_____

ARE THERE ANY OTHER RELEVANT MEDICAL HISTORY CONDITIONS/SURGERIES THAT I SHOULD KNOW ABOUT?

_____
_____
_____
_____
_____

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# Patient Insurance, Consent, and Cancellation Policy

I hereby authorize Brian Tenenhaus, from BT's Peak Performance, Therapy, and Wellness, LLC to furnish Physical Therapy treatment as indicated. I authorize Brian Tenenhaus to share any medical information, or any other necessary information regarding medical claims on my behalf to related physicians, healthcare practitioners and insurance carriers. I have received a copy of the HIPAA policy and procedures and it has been explained to me. My signature below authorizes PPTW to release medical records and any other pertinent information for reimbursement. My signature also indicates permission to be evaluated and treated by Brian Tenenhaus, a licensed Physical Therapist from BT's PEAK Performance Therapy and Wellness, LLC.

FINANCIAL Responsibility/Assignment of Benefits

I understand that BT's PEAK Performance, Therapy, and Wellness, LLC (PPTW) is OUT of NETWORK with my insurance company. I am responsible for paying $165.00 for all PT sessions. I am aware that my insurance company may or may not cover some, or all of my session, and any reimbursement from the insurance company will be given to me from the insurance company after BT's Peak Performance, Therapy and Wellness, LLC submits their claims. It is my responsibility to inform PPTW of any changes in coverage, or insurance carrier.

I understand that as a courtesy, PPTW will make every effort to verify the Out of Network Physical Therapy benefits prior to the beginning of physical therapy, however, it is my responsibility to confirm my Out of Network Insurance Benefits with my insurance carrier. PPTW will also electronically submit claims on the patient's behalf, and communicate with the patient's insurance company by providing any necessary clinical documents for Physical Therapy claims.

PPTW does not have a relationship with Medicare at this time. PPTW is not a medicare provider and cannot submit to or communicate with Medicare.

The patient, legal guardian or parent (under 18 years old) is responsible for the above mentioned fee for service.

Patient Signature acknowledges understanding of the above information

_____

There is no additional fee for Dry Needling services. Initial here if you consent to dry needling _____

Cancellation/late policy

Please arrive on time for your scheduled appointment. Brian runs on a very strict timing each day. Just as your time is very precious, so is his. Your appointment lasts for 1 hour, and it starts when you are scheduled, not when you arrive. If you cancel within 24 hours before the scheduled appointment, you will be charged in full, unless that slot is filled by a person on a waiting list.

Patient Signature Date

_____ _____

Patient Insurance Information

Insurance Carrier _____

Policy/ID Number _____

Group ID _____

Is patient the Primary Subscriber for the Insurance Y N (please circle one)

If not, who is ? (full name) _____

Primary Subscriber's Date of Birth _____

(for internal use only, to be filled out by PPTW)

Your health insurance carrier has verified that you have a $_____ yearly Out of Network deductible of which _____ has been met. Once your deductible has been satisfied, your insurance covers PT at _____%.

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**HIPAA Release of information Authorization Form & Consent for Treatment**

I, _____[Insert name] hereby authorize BT's PEAK PTW and its affiliates, to release my personal health information maintained by _____ _____(insert MD/MD office, other healthcare providers/personal trainers) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire _____ [Insert beginning date of services] and the date my coverage ends with _____[insert the end date].

I further understand that this authorization is voluntary and that I may refuse to sign this authorization.
NO, PLEASE DO NOT COMMUNICATE WITH OTHER HEALTHCARE PROVIDERS or INSURANCE COMPANIES ABOUT MY MEDICAL STATUS AND INFORMATION
_____ (sign) _____(date)

My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Or

YES, I authorize the sharing of pertinent medical information with other healthcare providers and insurance companies regarding my claims.

Name : _____ Signature: _____

Date:_____

YES, I consent to all treatment (initial here) _____

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# Directions and other Details

Below you will see the address and an approximate idea as to where we are located.

## 168 Boston Post Road in Madison CT

We are in the big building called **168 PRESTIGE PARK**

The entrance is on the side of the building, facing the rock wall where there is a **Dark Green Awning**

Parking is available to the right of the ally way, if you're looking at **SHAG Hair Salon**

There are 2 *other* PT clinics in the building, but remember, we are

**PEAK PERFORMANCE THERAPY AND WELLNESS**

Call if you are having a tough time getting there.

203-421-2435

What to expect when you arrive:

Upon arrival, there is a small waiting area in the entryway, however if you would like to come in and stretch on a mat or foam roll prior to your session, come on in. Relax, and mentally prepare for a great Physical Therapy Session. Proper attire is only going to help you benefit further from the PT session. Loose fitting tops/tank tops, sports bras, and shorts or loose-fitting pants help to allow for the best hands-on treatment.