FINANCIAL POLICY STATEMENT

Southern Nassau Physical Therapy, Western Nassau Physical Therapy and Seaside Physical Therapy/DBA Peak Performance Physical Therapy will bill your insurance carrier as a courtesy to you. Patient responsibility is explained to you and co-payments or other payments responsibilities are due at each visit. Coinsurance/deductible will be billed to you after we receive payment from your insurance company.

It is your responsibility to inform the front desk of any policy changes in your insurance immediately. Many of the insurances require prior authorization for physical therapy. In the event of a policy change it may be required to obtain prior authorization. This is one of the very important reasons for immediate notification of policy change. In the event your insurance company requests a refund for payments made, you are responsible for the amount of money refunded by insurance company. In the event your insurance company reimburses payment directly to your home, payment must be signed over to Peak Performance Physical Therapy. Estimated coverage information is provided to you as a courtesy. It is not intended to release you from any patient responsibilities. We recommend checking your own benefits with your insurance company.

Workers Compensation and No Fault patients: if your case is closed or coverage is no longer effective it is your responsibility to submit a copy of your commercial insurance card to the front desk or the billing department. Check with the front desk or billing department to see if Peak Performance is a participating provider. If you do not have other medical coverage you are responsible for payment of your bills.

In the event payments requested from our office are not received within 90 days your account will be forwarded to our collection agency. Please note: When your account is sent to our collection agency a 30% additional fee ________ (patient initials) will be added to your balance. Peak Performance offers payment plans to accommodate your financial requirements if requested at time of evaluation.

CANCELLATION POLICY

This is to notify you that we will charge you a $25 fee, for all appointments missed within less than a 24 hour notice. Our office does acknowledge extenuating circumstances and will take into consideration when charging the fee.

Signature of patient or patients representative                        Date

If this form is signed by the patient’s representative, please complete the following: Print the name of the Patient’s Representative:
MEDICAL HISTORY

Name: ___________________________ Age: ______ DOB: _______ Height_______ Weight_______

Describe your current complaint:________________________________________________________________________________________
________________________________________________________________________________________________________________________________

When did your condition begin? ___________________ How did your problem begin? ____________________________

Have you been treated for this same problem in the past? Yes or No
If yes, please describe: ___________________________________________________________________________________________

Have you had Surgery? Yes or No
If yes, please describe: ___________________________________________________________________________________________

Have you fallen in the last year? Yes or No

Current level of pain (0 = no pain, 10 = require emergency room care):

At rest: 1 2 3 4 5 6 7 8 9 10
With movement: 1 2 3 4 5 6 7 8 9 10

Since your condition began, have your symptoms: decreased not changed increased

What makes your problem better? ____________________________________________________________

What makes your problem worse? ____________________________________________________________

What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%

Please mark on the drawings below where you feel your pain:

Please check any of the following services that you have received for this condition:

___ Orthopedist  ___ Physical Therapy  ___ X-Rays
___ Chiropractor  ___ Occupational Therapy  ___ CT Scan
___ Neurologist  ___ Massage Therapy  ___ MRI
___ General Practitioner  ___ Myelogram  ___ Injection
___ Emergency Room  ___ CT Scan  ___ Cast or Brace

PT INITIALS: __________________
Please list any medications you are currently taking: __________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
___________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Have you experienced dizziness and or Vertigo? __________________________________________________
If so, When? ____________________________________________________________

Please check any of the following that are in your health history:

___ Asthma
___ Shortness of Breath
___ Coronary Artery Disease
___ Chest Pain
___ Pacemaker
___ High Blood Pressure
___ Heart Attack
___ Heart Surgery
___ Stroke or TIA
___ Blood clot or emboli
___ Epilepsy or Seizures
___ Thyroid trouble or Goiter
___ Fearful of water (in regard to Aquatic Therapy)
___ Sleeping Problems
___ Emotional/Psychological
___ Headaches
___ Numbness/Tingling
___ Fainting
___ Blurred Vision
___ Ringing in the Ears
___ Weakness
___ Weight Loss
___ Night sweats
___ Hernia
___ Varicose Veins
___ Allergies
___ Anemia
___ Infectious Disease
___ Neurological Problems
___ Diabetes
___ Metal Implants
___ Cancer
___ Smoking
___ Arthritis/swollen joints
___ Check if Pregnant
___ Osteoporosis
___ Incontinence

Please list any past surgeries: _____________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please list any past hospitalizations: _____________________________
__________________________________________________________________________________________

Please list three goals you would like to achieve while in physical therapy:
1. ________________________________________________________________________________________
2. ________________________________________________________________________________________
3. ________________________________________________________________________________________

Patient/Guardian Signature: ___________________________________________ Date: _________________

I have read and reviewed the medical history of __________________________________________________
__________________________________________________________________________________________

___________________________

Physical Therapist Signature Date
PATIENT CONSENT

1. I, understand, do hereby agree and give my consent for Peak Performance Physical Therapy to furnish my medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition.

2. I acknowledge that I have been given a copy of the Notice of Privacy Practice, which describes the Practice's obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the practice's HIPAA Privacy Notice and to ask for clarification of it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of the HIPAA Privacy Notice.

3. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance on this consent.

4. I hereby assign all medical and/or surgical benefits to include medical benefits, to which I am entitled, including Medicare, private insurance and third party payers to Peak Performance Physical Therapy.

_________________________________________   ___________________________________
Signature of patient or patients representative         Date

If this form is signed by the patient's representative, please complete the following:

Print the name of the Patient's Representative: ____________________________

Describe the representative's authority to act for the patient: ____________________

_________________________________________

Should you refuse to sign the above document Peak Performance P.T. reserves the right to refuse to provide non-emergency care to the patient.
Frequently Asked Questions

The staff at Peak Performance has compiled a list of frequently asked questions that may be of service to you. Please find the questions and answers below:

What is Physical Therapy?

You have inquired about our Physical Therapy services for the preservation, development, and restoration of physical function. At Peak Performance, we focus on the management of a wide variety of musculoskeletal conditions, and our treatment programs include exercise, manual therapy techniques, modalities and balance activities.

Why did my doctor prescribe Physical Therapy?

Your doctor has determined that you require skilled Physical Therapy intervention to rehabilitate your injury or condition. Condition dependent, Physical Therapy can be an effective way to avoid surgery, restore mobility, strength and function after injury and to safely rehabilitate post-operative conditions. Your specific therapy requirements are discussed with your therapist after a thorough initial evaluation.

How many times a week should I attend therapy?

Your physician, your physical therapist and you will determine frequency of therapy sessions. Most sessions are 2-3 times per week but may vary depending on your specific diagnosis.

Can I attend 2 consecutive days of therapy?

Although we encourage at least 1 day of rest in between visits, if necessary, you can schedule back-to-back appointments unless otherwise determined by your physical therapist. If unsure, always consult your individual therapist.
**Why am I sore after therapy?**

Our role in your rehabilitation involves mobilization of your “injured part” and exercises tailored specifically for you. Therefore there is potential for soreness and/or aching following your initial evaluation and/or treatment session. You should not experience sharp pain, and the degree of soreness as well as timing of onset will tell us a great deal about your specific response to treatment. Some soreness is normal and should subside within 24-48 hours. Your therapist will discuss your specific expectations. Please feel free to discuss this with our clinical staff at any time.

**What do I do if I have pain?**

*Unless your therapist has instructed you otherwise it is common practice to apply ice to your injured body part following physical therapy sessions. You can use an ice pack or ice cubes in a plastic bag for up to 15 minutes every hour. DO NOT apply ice directly to your skin and always use a light towel or pillowcase to avoid an ice burn.*

**Should I come in for my appointment if I am in pain?**

In many cases, attending your scheduled appointment can be a way for us to help expedite reducing the inflammatory response, and is encouraged. Your therapist can modify your treatment plan to accommodate your current symptoms if this occurs. There is potential for soreness to occur for a period of 24-48 hours following your physical therapy session, which is normal. If you are unsure based on your particular response, you can call and speak with your therapist.

**My doctor gave me an injection, can I still attend therapy?**

It is common to wait 1-3 days after an injection to resume therapy unless otherwise specified by your physician. Please let your therapist know if you are having an injection and speak to your physician regarding specifics.

**Can I use the gym if I am a physical therapy patient?**

Although you may utilize some of the equipment in the gym during your physical therapy sessions, a gym membership is required for private use. Any of our fitness staff** would be pleased to assist you with questions you may have.

**What is authorization?**

Authorization is when your insurance company gives the approval for payment of physical therapy visits. Not all insurances require authorization, and you should ascertain the details of your particular coverage prior to initiating a program.

**Why do I have to get new prescriptions?**

Your prescription is valid for the amount of time that your physician prescribed *from the date it was written*. Most insurance plans will NOT cover treatment without a *valid* New York State prescription, and Peak Performance policy requires that you have a valid script.