



PEAK PHYSICAL THERAPY, P.C.

260 North St. • Newburgh, NY 12550 • (845) 565-5054 • Fax (845) 565-4071

Daniel J. Fishman, PT, CHT, MTC Director

www.peakpt.com

PATIENT INFORMATION/WORKERS' COMPENSATION

FIRST NAME: _____ DATE INJURED ____/____/____
LAST NAME: _____ TODAY'S DATE ____/____/____
BIRTH DATE ____/____/____

ADDRESS: _____
ZIP _____

PHONE #:() _____ CELL PHONE#() _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

PATIENT SEX: M F

PATIENT'S SOC. SEC. # ____/____/____

MARITAL STATUS: SINGLE _____ MARRIED _____ OTHER _____

EMPLOYMENT STATUS: EMPLOYED _____ F/T STUDENT _____ P/T STUDENT _____

PRIMARY PHYSICIAN: _____

REFERRING PHYSICIAN: _____

ARE YOU CURRENTLY SEEING A CHIROPRACTOR? Y N

IF YES, NAME OF CHIROPRACTOR: _____
ADDRESS: _____
ZIP _____

HOW DID YOU FIRST LEARN ABOUT PEAK PHYSICAL THERAPY? _____

EMPLOYER AT TIME OF INJURY: _____
ADDRESS: _____
ZIP _____

PHONE #:() _____

PRESENTLY WORKING? Y N OCCUPATION: _____

W/C CARRIER: _____

ADDRESS: _____
ZIP _____

ATTN: _____

ATTORNEY: _____

ADDRESS: _____
ZIP _____ PHONE#() _____

IN THE EVENT THAT YOUR WORKERS' COMPENSATION CLAIM IS DENIED, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF PRIVATE INSURANCE CARRIER: _____
ADDRESS: _____

TELEPHONE () _____ ID# _____

I HEREBY CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR THESE SERVICES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND AUTHORIZE MY INSURANCE COMPANY TO PAY PEAK PHYSICAL THERAPY, P.C. DIRECTLY FOR SERVICES RENDERED.

IF YOU MUST BRING SOMEONE WITH YOU TO THERAPY, WE REQUEST THAT THEY REMAIN IN THE WAITING ROOM.

PATIENT'S SIGNATURE _____ DATE: _____
(GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE)



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APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress and also may adversely affect my disability status.

APPOINTMENTS:

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours for cancellation.

RESPONSIBILITY:

It is your responsibility to contact your insurance company to verify your coverage for out-patient physical therapy. You need to verify your percentage of payment per visit, any co-payments, deductibles and limits of visits per calendar year. We at Peak Physical Therapy will be glad to bill your insurance as a courtesy to you. But it is your responsibility for any portion not paid by insurance. If you need any assistance in this matter, please feel free to contact our business office or see the receptionist.

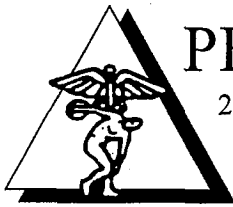
I have read and understood the above stipulations and agree to comply with the appointment policy. I hereby give Peak Physical Therapy permission to perform physical therapy as prescribed by my physician on myself or my child (if applicable).

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I have had access to Peak Physical Therapy's Notice of Privacy Practices. Should I have any questions regarding this notice, I understand that I can contact the Practice at 845-344-0168.

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SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR) DATE



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NAME: _____ DATE: _____

CHECK APPROPRIATE BOX IF YOU NOW HAVE OR HAD ANY OF THE FOLLOWING:

LUNG/BREATHING PROBLEMS/ASTHMA	YES _____	NO _____
CANCER	YES _____	NO _____
DENTAL PROBLEMS	YES _____	NO _____
DIABETES	YES _____	NO _____
HIGH BLOOD PRESSURE	YES _____	NO _____
BLOOD VESSEL DISEASE/VASCULAR PROBLEMS	YES _____	NO _____
HEART ATTACK/HEART PROBLEMS	YES _____	NO _____
PACEMAKER	YES _____	NO _____
HEADACHES	YES _____	NO _____
HEARING AID	YES _____	NO _____
JOINT REPLACEMENTS	YES _____	NO _____
METAL IMPLANTS/FRAGMENTS	YES _____	NO _____
ARTHRITIS	YES _____	NO _____
NERVOUS SYSTEM DISORDER/STROKE	YES _____	NO _____
VISUAL IMPAIRMENT	YES _____	NO _____
KNOWN ALLERGIES	YES _____	NO _____
PREVIOUS SURGERIES (PLEASE LIST WITH DATES)	YES _____	NO _____
SEIZURES	YES _____	NO _____
DIZZINESS	YES _____	NO _____
PREGNANT NOW	YES _____	NO _____
ALCOHOL/DRUG ABUSE	YES _____	NO _____
INFECTIOUS DISEASE	YES _____	NO _____
SMOKER	YES _____	NO _____
FRACTURES	YES _____	NO _____
SKIN CONDITION	YES _____	NO _____
OPEN WOUNDS	YES _____	NO _____
DEPRESSION	YES _____	NO _____
OSTEOPOROSIS	YES _____	NO _____

IF YOU HAVE CHECKED YES TO ANY OF THE ABOVE, EXPLAIN AND GIVE DATES:

LIST ALL CURRENT MEDICATIONS AND DOSES (incl. over-the-counter, herbals, vitamin/mineral/dietary supplements) :

THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. THE PHYSICAL THERAPIST WILL EXPLAIN ALL TREATMENT DONE TO ME, THE DIAGNOSIS, TREATMENT PLAN, PROGNOSIS, TREATMENT ALTERNATIVES AND ANY POSSIBLE ADVERSE OUTCOMES.

DATE: _____
PATIENT'S SIGNATURE _____

REVIEWED BY _____ P.T.



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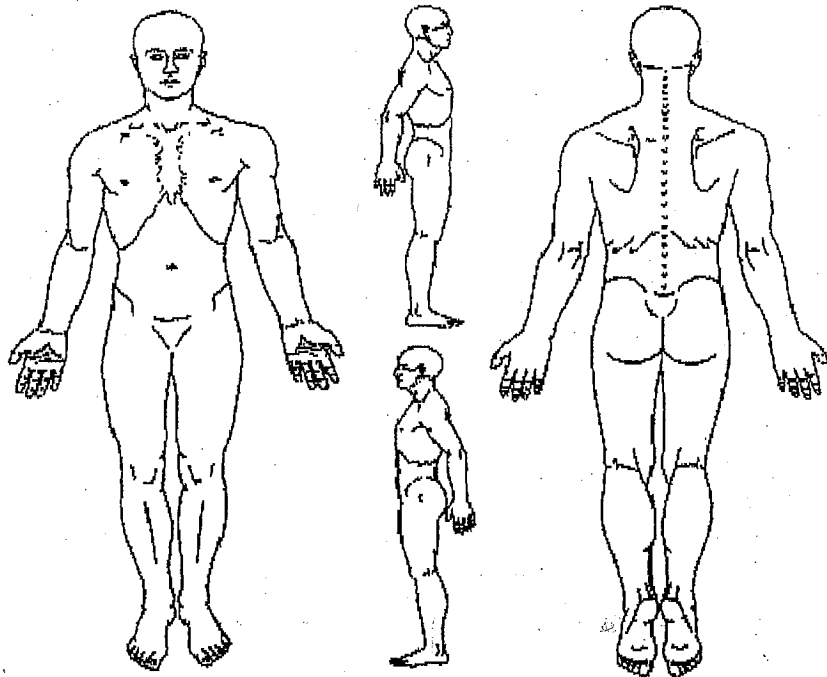
www.peakpt.com

Patient Name _____ Date ____/____/____

How long have you had your symptoms? ____ days ____ weeks ____ months ____ years

On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

- | |
|--------------------|
| A = ACHE |
| B = BURNING |
| N = NUMBNESS |
| P = PINS & NEEDLES |
| S = STABBING |
| O = OTHER _____ |



Please select all that describes your pain and circle the intensity for each one selected:

Description of Pain	Intensity		
	Mild	Moderate	Severe
Throbbing			
Shooting			
Stabbing			
Sharp			
Cramping			
Gnawing			
Hot / Burning			
Aching			
Heavy			
Tender			
Splitting			
Tiring / Exhausting			
Sickening			
Fearful			
Punishing / Cruel			



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AUTHORIZATION FORM

I, _____, hereby authorize Peak Physical Therapy to disclose my protected health information to:

NAME OF PERSON	RELATIONSHIP TO PATIENT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

This authorization shall be in effect until _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Anita Confrey at 260 North Street or www.peakpt.com. I understand that a revocation is not effective to the extent that Peak Physical Therapy has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or refuse to sign this authorization. Peak Physical Therapy will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



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FINANCIAL POLICY

We are committed to providing you with the best possible care, and at Peak are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask the secretarial staff if you have any questions about our fees, financial policy, or your responsibility.

Payment is due for services at the time services are rendered. All coinsurance, copayments, and deductibles are due as services are rendered. We submit all billing to insurance companies as a courtesy to our patients; however, we will collect the 20%, deductibles and copayments at time of visit.

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made), the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

I understand and agree to comply with the Financial Policy explained above.

Signature of Patient or Guardian (if minor)