Welcome!!!

Thank you for choosing Peak Physical Therapy!

What to Expect On Your First Visit:

- Please arrive 10-15 minutes prior to your first appointment to review your insurance benefits, complete necessary paperwork and change into comfortable clothing.

- A physical therapist will perform a thorough evaluation of your condition. We will review your medical history, current complaints, functional limitations and goals. The therapist will assess your posture, range of motion, strength and functional biomechanics. You will work together with your physical therapist to develop a comprehensive treatment program that will address all of your needs.

What to Bring:

- Completed New Patient Forms
- Insurance Card and Photo ID
- Signed prescription from your MD

Please dress in comfortable and appropriate clothing and shoes so the therapist may access the injured area

*If you have any questions call us at (408)366-1735 or Visit our website at www.peakptcupertino.com

We are located at

10580 S. De Anza Blvd, Cupertino, CA 95014

From 280

- Take 280 towards Cupertino
- Exit De Anza Blvd South
- Travel to Bollinger Rd.
- Make a U-turn and head North on De Anza Blvd.
- Arrive at 10580 S De Anza Blvd, Cupertino, CA 95014 on Right

From 85

- Take CA-85 towards Cupertino
- Exit De Anza Blvd, travel North on S. De Anza Blvd.
- Arrive at 10580 S De Anza Blvd, Cupertino, CA 95014 on Right

Look for a bright orange “Aqui Restaurant” sign and turn into that driveway, we are in the back left corner of that parking lot

PEAK PHYSICAL THERAPY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Uses and Disclosures:

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Peak Physical Therapy. For example, information on services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Upon court order, your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Individual rights. You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed a copy of this notice.

Peak Physical Therapy duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Requests to Inspect Protected Health Information. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your Physical Therapist.

Complaints. If you would like to submit a comment or complaint about our privacy practices or if you believe your privacy rights have been violated, please send us a letter outlining your concerns to:

Peak Physical Therapy
10580 S. De Anza Blvd.
Cupertino, CA 95014

You will not be penalized or otherwise retaliated against for filing a complaint.

IMPORTANT INSURANCE INFORMATION

We do our best to be as transparent as possible regarding the cost of your treatment. It can be very difficult to estimate the exact cost due to the great variety of insurance plans and coverage which is unique to each individual. In addition, treatment fees are based upon specific codes that are submitted after each visit and these codes may vary from visit to visit depending upon what is done during that treatment. We highly recommend that you contact your insurance company to get your specific benefits.

During the period that you are at Peak Physical Therapy, you may receive an Explanation of Benefits (EOB) from your insurance company. Please DO NOT take the amount charged per visit as the amount you owe. In some cases, the amount noted as your responsibility may not take into account all contractual adjustments. On your behalf, our billing department will resubmit the claim to get the maximum reimbursement from your insurance company. The most accurate statement will be the one you receive from Peak Physical Therapy.

Some helpful definitions of terms on the EOB:

Deductible: A deductible is a fixed amount you pay each year before your health insurance pays a benefit. Once you've paid your deductible, your health plan begins to pay its share of your health care bills.

Co-insurance: The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copay: A copayment is a fixed amount you pay each time you receive a health care service.

Contractual Adjustment: This is a discount the insurance company and you receive for using an in-network provider. To be in network, a medical provider accepts a contract with the insurance plan which includes an adjustment to the total cost of care known as the allowable amount. The total cost minus the allowable amount is the contractual adjustment or discount. Providers that participate in the agreement believe that the broader access to members is worth the contracted rates on services and in turn, patients that use an in-network provider pay less than if they used an out of network provider.

If you have any questions or concerns, please call and we will be more than happy to help you.

Thank you,

Peak Physical Therapy

PEAK PHYSICAL THERAPY

Patient Information

Patient Name: Last: _____ First:_____ Date of Birth: _____

Address: _____ Male □ Female □ Marital Status _____

City: _____State: _____ Zip: _____ Is injury the result of an accident? (Y/N) _____

E-mail: _____ Work Related? (Y/N) _____ Auto (Y/N) _____

Date of Injury: _____

Home Phone: _____ **(Responsible party-Primary Subscriber)**

Work Phone: _____ Name: _____

Cell Phone: _____ Address: _____

Patient Employer:
Name: _____

Emergency Contact:
Name: _____

Address: _____ Phone: _____ Relationship: _____

City: _____ State: _____ Zip: _____ **Prescribing Doctor:** _____

Occupation: _____ **How did you hear about our clinic?** _____

Please read the following and Initial in the corresponding box.	Initial
Consent to Treatment: I consent to rehabilitation and related services at Peak Physical Therapy. I doing so, I understand that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.	
Treatment of Minors: I, as parent/guardian of a minor receiving treatment, understand and agree that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.	
Liability: I know and agree that Peak Physical Therapy is not responsible for loss or damage to personal valuables.	
Waiver and Release: I release Peak Physical Therapy from all liability, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physician or urgent care services.	
Authorization of Payment: I assign all benefits directly to Peak Physical Therapy and authorize release of any medical records necessary to facilitate my treatment to process medical claims. I understand that in the event my insurance company does not pay for the services I receive, I will be financially responsible for payment.	
Notice of Privacy: I acknowledge receipt of the Peak Physical Therapy Notice of Privacy Practices.	
Cancellation Policy: Monday appointments require to be rescheduled or cancelled at least 72 hours in advance, Tuesday to Friday appointments need to be rescheduled or cancelled 24 hours in advance.	
Returned Check Policy: A $25 fee will be issued for a returned check of non-sufficient funds.	
Collection Fee, Attorney Fees & Interest: I agree to pay interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee of up to 40% of the principal balance if my account is assigned to a collection agency.	

I certify that all of the information provided is true and correct.

Patient/Guardian Signature: _____ Date: _____

PEAK PHYSICAL THERAPY
APPOINTMENT CANCELLATION / NO SHOW POLICY

TO: **OUR PATIENTS**

FROM: PEAK PHYSICAL THERAPY

On occasion patients have not shown up for their appointment or cancel their appointment at the last minute. For this reason, Peak Physical Therapy has a Cancellation/No Show Policy.

We require any Monday appointment to be rescheduled or cancelled at least 72 hours (3 days) in advance. Tuesday, Wednesday, Thursday and Friday appointments need to be rescheduled or cancelled at least 24 hours in advance. Failure to comply will result in a charge of $40.00 to your account.

We appreciate your cooperation and consideration in this matter. If you have any questions, please don't hesitate to ask or call.

Please sign indicating that you understand this policy:

_____ _____

Signature Date

PEAK PHYSICAL THERAPY
MEDICAL HISTORY INFORMATION

Patient Name: _____ **DATE:**_____

Height:_____ Weight:_____

Are you presently taking any medications? ☐ Yes ☐ No

(Please list):_____

_____

Do you have any allergies? ☐ Yes ☐ No

Please List: _____

Please check if you have had or now have any of the following:

Y	N		Y	N	
		HIGH BLOOD PRESSURE			DIZZINESS
		CHEST PAIN			OSTEOPOROSIS
		HEART ATTACK			LUNG DISEASE
		PACEMAKER			TUBERCULOSIS
		DIABETES			SMOKER
		SEIZURES			HIV+/AIDS
		STROKE			HEPATITIS
		CANCER			EPILEPSY
		ASTHMA			JOINT REPLACEMENT/ PINS
		MAJOR ILLNESS/MAJOR ACCIDENT			BLADDER PROBLEMS
		REACTION TO CHEMICALS			KIDNEY DISEASE

FOR WOMEN:

		Could be pregnant now?

General Information:

Have you ever been hospitalized or had surgery? Yes ☐ No ☐

If yes, when and for what? _____

Have you ever participated in a physical therapy program before? Yes ☐ No ☐

If yes, when, how long, and for what?_____

_____

Please share any other information that you feel would be useful to our staff. _____

_____

_____

Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

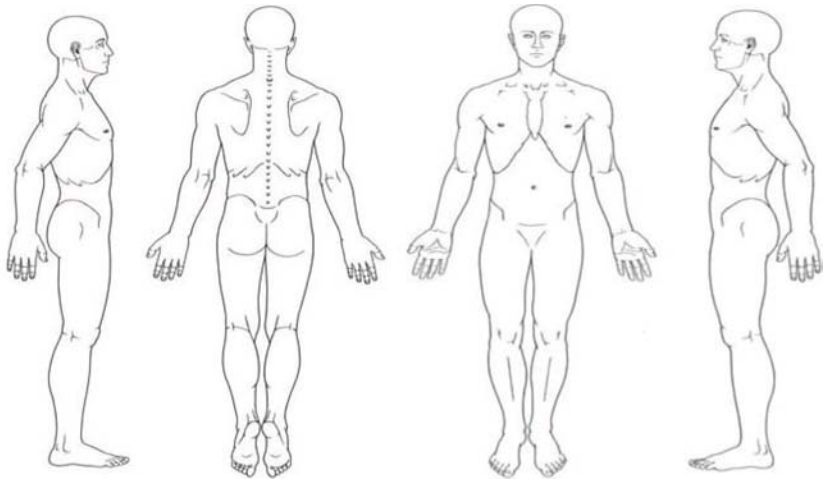
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Peak Physical Therapy
Disabilities of the Arm, Shoulder, and Hand (quickDASH)

Instructions: Please circle the number of the statement that most closely describes your ability to do the following activities **in the last week**. If you did not perform one of the listed activities in the last week, please make your best estimate for the most accurate response. It does not matter which hand/arm you use to perform the activity.

Patient Name: _____ Date: _____

Please rate your ability to do the following activities in the last week	**No Difficulty**	**Mild Difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**Unable to Perform**
Open a tight or new jar	1	2	3	4	5
Do heavy household chores (e.g. wash walls, wash floors, etc.)	1	2	3	4	5
Carry a shopping bag or briefcase	1	2	3	4	5
Wash your back	1	2	3	4	5
Use a knife to cut food	1	2	3	4	5
Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g. golf, hammering, tennis, etc.)	1	2	3	4	5
	Not At All	**Slightly**	**Moderately**	**Quite a Bit**	**Extremely**
During the past week, to what extent has your arm, shoulder, or hand problem interefered with your normal social activities with family, friends, neighbors, or groups?	1	2	3	4	5
	Not At All Limited	**Slightly Limited**	**Moderately Limited**	**Very Limited**	**Unable**
During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem?	1	2	3	4	5
Please rate the severity of the following activities in the last week	**None**	**Mild Difficulty**	**Moderate**	**Severe**	**Extreme**
Arm, shoulder, or hand pain	1	2	3	4	5
Tingling (pins and needles) in your arm, shoulder, or hand	1	2	3	4	5
	No Difficulty	**Mild Difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**I Can't Sleep**
During the past week, how much difficulty have you had in sleeping because of the apin in your arm, shoulder, or hand?	1	2	3	4	5
Sum of each column					

Sum of Responses: _____ / 55

For Therapist Use: At least 10 of the 11 items must be completed. A higher score indicates greater disability.

To Calculate score: [(sum of n responses ÷ n) -1] x 25=_____