PEAK PHYSICAL THERAPY
"keeping your body in motion"

10580 S. De Anza Blvd. Cupertino, CA 95014
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www.peakptcupertino.com

Welcome!

Thank you for choosing Peak Physical Therapy

What to expect at your initial evaluation:

- **Arrive at least 15 minutes prior to your initial evaluation.** This gives you time to check in, review your insurance benefits, and complete any additional paperwork so you can take advantage of your full treatment time with your Physical Therapist.
- **Your initial evaluation appointment will be up to one hour long, one-on-one, with the Physical Therapist.** For your follow up appointments, the first half will generally be spent with the Physical Therapist, while the second half will be spent doing exercises with a Physical Therapy Aide.
- During your initial evaluation, **your physical therapist will perform a thorough evaluation of your condition**. They 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 your needs.

What to bring to your initial evaluation:

- Your completed New Patient Forms
- Your insurance card(s) and Photo ID
- Your referral or prescription from your Doctor
- Your calendar for future scheduling

As a reminder, please wear loose, comfortable clothing because you will begin exercising at your initial evaluation. For example, if you're coming in for your shoulder, please bring a t-shirt or a tank top. If you are coming in for your knee, bring shorts. See you soon!

If you have any questions, contact us at (408) 366-1735 or visit our website at www.peakcupertino.com

PEAK PHYSICAL THERAPY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information may be used and disclosed, and how you can get access to this information. Please review the following **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 require 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 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 the following address. You will not be penalized or otherwise retaliated against for filing a complaint.

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

PATIENT INFORMATION

Section 1: Patient Demographic Information: *If there has been no change to this info, check this box ⇒* ☐

First Name: _____ **Last Name:** _____

Date of Birth (*MM/DD/YYYY):* _____/_____/_____ Male: ☐ Female: ☐ Marital Status: _____

Address: _____ Cell Phone: _____ Consent to Text: ☐

City: _____ Home Phone: _____

State: _____ Zip: _____ Work Phone: _____

Email: _____

Section 2: Primary Insurance Subscriber Information. *If there has been no change, check this box ⇒* ☐

First Name: _____ **Last Name:** _____

Address: _____ Male: ☐ Female: ☐ Relationship: _____

City: _____ Date of Birth (*MM/DD/YYYY):* _____/_____/_____

State: _____ Zip: _____

Section 3: Emergency Contact

Name: _____

Relationship: _____

Phone #: _____

Section 4: Other

Prescribing Dr. Name: _____

How did you hear about Peak?

_____

Section 5: Disclaimer

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. In 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 resulted 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.	
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.	

Patient/Guardian Signature: _____ Date: _____

PEAK PHYSICAL THERAPY Appointment Cancellation & No-Show Policy

Patients who attend all their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lowered potential for recovery. We do what we do to make sure YOU, and all our patients, have the best chance at recovery; but, we need your participation in the plan of care to make that happen. To prevent others from having to wait for their care, we also need your compliance with our appointment cancellation and no-show policy.

Read our policy & sign at the bottom indicating you understand our expectations and policy.

1. **We strive to start on time,** so arrive for your scheduled appointment on time.
2. **If you're running late, contact us as soon as you know you're running late.** We will check with your provider to make sure there's enough time to provide the care you need and deserve.
   - If you are more than 15 minutes late, your session may need to be rescheduled and our missed visit policy will apply at that time. Chronically late patients will be asked to change their appointment times.
   - Medicare requires a certain amount of direct supervision by a Physical Therapist per appointment. As a result, if a Medicare patient arrives later than 10 minutes, we are unable to keep the appointment with that patient due to compliance issues, and the patient will be charged a $40 missed appointment fee.
3. **If you are sick at any time, contact us as soon as you have symptoms**. Please don't wait for the day of your appointment. At that time we will provide a plan for what happens next.
   - Example: If you're sick on Monday but your appointment is Wednesday, let us know Monday.
4. **If you need to cancel or change a scheduled appointment for any reason, notify us at least one business day in advance of your appointment time. If you don't provide notice, you will be charged a $40 fee.** That means Tuesday through Friday appointments need to be canceled at least 24 hours in advance of your appointment time and Monday appointments to be rescheduled or canceled at least 72 hours (3 days) in advance of your appointment time.
   - We have a courtesy text and email reminder system, but *strongly* encourage each patient to have personal reminders instead of relying on that technology because it can have issues.
   - This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
   - This fee is your responsibility and is due at the time of your next service due to the inconvenience and disruption it creates for other patients seeking care.
   - No-show appointments cause disruption and confusion, which are not conducive to our professional standards. Please contact us for changes and updates to your schedule.
5. **Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and placed on our waitlist to avoid future last-minute cancellations that keep other patients from care.**

Contact our office during business hours (**review them below**) at least one business day in advance of your appointment time for any illness, appointment changes, or cancellations.

Peak Physical Therapy Business Hours

Saturdays, Sundays, & Holidays: Closed
Mondays: 8:00am - 7:00pm
Tuesdays: 7:00am - 7:00pm
Wednesdays: 7:30am - 7:00pm
Thursdays: 7:00am - 7:00pm
Fridays: 7:30am - 6:00pm

This policy has been reviewed with me and by signing below I am indicating I understand this policy.

_____	_____	_____
Patient/Guardian Signature	Patient Name	Date

MEDICAL HISTORY

Patient Name:_____ **Date:** _____

Height: _____ **Weight:** _____

Are you presently taking any medications? ☐ ***YES*** ☐ ***NO***

If yes, please list: _____

_____

_____

Do you have any allergies? ☐ ***YES*** ☐ ***NO***

If yes, 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?

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 _____

_____

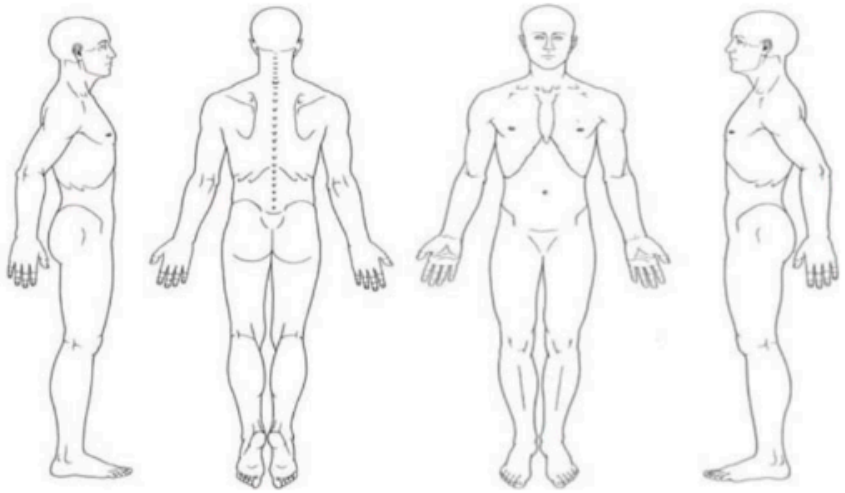
a. When did your symptoms start? _____

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

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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

PEAK PHYSICAL THERAPY

Disabilities of the Arm, Shoulder, and Hand (quickDASH)

Patient Name: _____ **Date**: _____

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.

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 your 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 interfered 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 pin 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 responses ÷ n)] x 25 = _____