Peak Performance Sports & Spine

PATIENT INFORMATION		
Last Name:		First Name:
DOB:	SSN:	Cell Phone:
How do you prefer to receive appointment reminders?	☐ Text to cell phone	☐ Receive automated voice call on primary #

Emergency Contact Person	
Last Name:	First Name:
Relation to patient:	Phone #:

ACKNOWLEDGEMENT OF
***Notice of Privacy* PRACTICES**

I have been informed - either in writing or verbally by a staff member- of the "Notice of Privacy" practices *(HIPAA regulation)* of Peak Performance Sports & Spine.

Signature: _____ Date: _____

ATTENDANCE POLICY

All appointments cancelled with less than a 24 hour notice, and appointments missed with no notice, will be subject to a **$50.00 fee**. I have read, understand and agree to this policy.

Signature: _____ Date: _____

NON-MEDICARE LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum insurance benefits have been met and I agree to pay for services at full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

_____ _____
Date Signature of Guarantor

MEDICARE
LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for any services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.

_____ _____
Date Signature of Guarantor

Peak Performance Sports & Spine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize Peak Performance Sports & Spine to obtain copies of my past and current medical records from your office.

(Please mark any of the following tests related to this condition / injury you had)

MRI ☐
CT scan ☐
X-ray ☐

Valley Imaging ☐ Memorial Hospital ☐ Regional Hospital ☐

Other: _____

Please fax indicated records to 509-453-7330, or mail to:
2505 Racquet Ln, Yakima, WA 98902.

Thank you for your prompt response.

To: _____

Regarding: _____

Patient Name: _____

Patient Signature: _____

Date: _____

PEAK PERFORMANCE

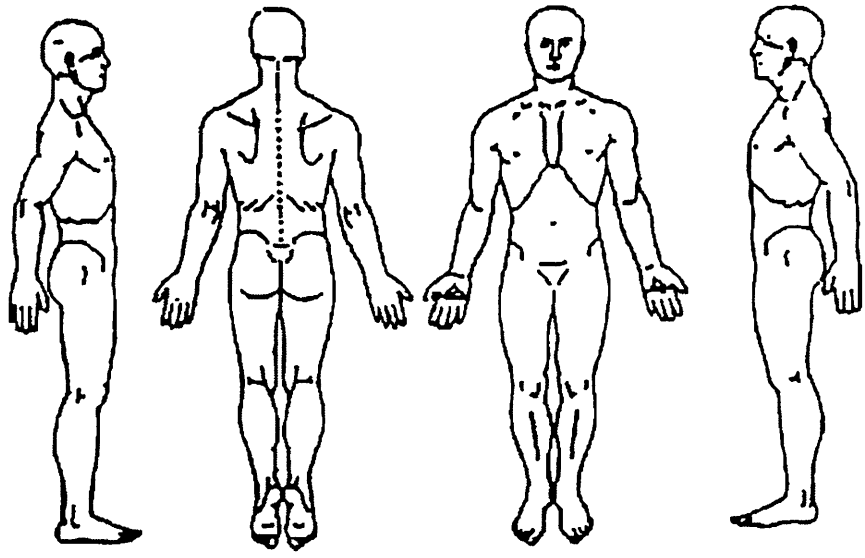
Patient Intake Form

Last Name,	First Name,	MI	Birthdate	Today's Date

Date of Injury/Onset: _____ **Duration of Symptoms:** _____

Are you currently experiencing pain? ☐yes ☐no

Indicate areas of pain on the diagram below:



Describe pain:
- ☐sharp
- ☐burning
- ☐aching
- ☐numbness
- ☐pulsating

Please circle the number that indicates your *worst pain level* with activity today.

No pain 0 1 2 3 4 5 6 7 8 9 10 *Worst pain imaginable*

Diagnostic tests related to current condition:

☐ Bone scan	☐ Labs	☐ NCV/EMG	☐ X-ray
☐ CT Scan	☐ MRI	☐ Ultrasound	☐ Other _____

Are you experiencing any of these conditions related to your current problem/complaint? ☐ yes ☐ no

If yes, please specify:

☐ Chest pain or pressure	☐ Nausea/Vomiting	☐ Under doctor's care
☐ Bowel/bladder function difficulty	☐ Night sweats/Night pain	☐ Unexplained shortness of breath
☐ Dizziness/fainting	☐ Numbness in genital/anal area	☐ Unexplained weakness
☐ Fever/Chills	☐ Pregnant *# of weeks?* _____	☐ Unexplained weight change
☐ Headaches	☐ Problems w/vision, hearing, speech	☐ Other _____

--- Continue to page 2

Fall Assessment: Have you had two (2) or more falls in the past 12 months? ☐ yes ☐ no

Have you had any falls in the past 12 months? ☐ yes ☐ no

Allergies: Are you allergic/sensitive to latex or adhesives? ☐ yes ☐ no

Do you have any other allergies? ☐ yes ☐ no

If yes, please list: _____

Please indicate any prior surgeries or medical conditions:

Condition/Surgery	**Description**
☐ Cancer	
☐ Cardiac	☐ *High Blood Pressure* ☐ *Heart Attack* ☐ *Congestive Heart Disease*
☐ Endocrine	☐ *Diabetes* ☐ *Thyroid Condition*
☐ Genitourinary	
☐ Infection	
☐ Neurologic	☐ *Stroke* ☐ *Seizures* ☐ *Multiple Sclerosis*
☐ Orthopedic	☐ *Osteoporosis*
☐ Pulmonary	
☐ Reproductive	
☐ Implanted Devices	☐ *Pacemaker* ☐ *Nerve Stimulator* ☐ *Pump Device* ☐ *Deep Brain Stimulator*
☐ Other	

Home Environment:

☐ Indoor stairs with railing? *How many?* _____ ☐ Outdoor stairs with railing? *How many?* _____

☐ Indoor stairs without railing? *How many?* _____ ☐ Outdoor stairs without railing? *How many?* _____

Employment Status: Occupation, if applicable: _____ Hours/week: _____

☐ Full Time
☐ Part Time
- ☐ *Work without restrictions*
- ☐ *Work same job with restrictions*
- ☐ *Work different job with restrictions*

☐ Retired
☐ Disabled
☐ Unemployed
- ☐ *Unable to work due to current condition*

Social History: Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Yes *#/day:* _____

Alcohol Use: ☐ Never ☐ Previously, but quit ☐ Yes *Drinks/day:* _____

Drug Use: ☐ Never ☐ Previously, but quit ☐ Yes *Specify:* _____

By signing your name below, you agree that the information that has been provided is true to the best of your knowledge.

Patient Signature: _____ Date: _____

For office use only

Form reviewed by (*PT initials*): _____ Date: _____