11750 Business Park Drive
Waldorf, MD 20601
P.O. Box 1066
Waldorf, MD 20604

Phone: 240-718-8103
Fax: 240-523-8728
Email: ppts@peacockpts.com
Website: www.peacockpts.com

Peacock Physical Therapy Services, LLC

New Patient Information/Intake Packet

Please obtain or complete the following and bring with you:

Referral from your Physician (if applicable)

Insurance Card & Picture Identification

Medication List with name & dosage (if applicable)

Patient Information & Medical History Forms (Pages 5-6)

Physical Therapy Medical Consent Form & Missed Visit Policy (Page 7)

Patient Rights, Responsibility, & Privacy Policy Consent Form (Page 8)

Wear/bring comfortable clothing (i.e. gym clothing & sneakers)

For upper body problems wear/bring tank top; For lower body problems wear/bring shorts

Most insurance carriers require a copay, coinsurance, or deductible for physical therapy services. Please come prepared to pay this at the time of service. Under certain circumstances we do offer payment plans. You can contact your insurance company via the "1-800" number on the back of your insurance card if you have any questions about your physical therapy benefits.

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Peacock Physical Therapy Services, LLC

Welcome to Peacock Physical Therapy Services, LLC!!! We appreciate the opportunity to treat you. There are a few things we would like to share to make your appointment run smoothly.

•Please remember to bring your referral/prescription and any other information your physician has given you.

•Please fill out the paperwork that is provided in this packet prior to your appointment time. If your paperwork is not completed, please arrive at least 15-20 minutes earlier than your appointment time in order to complete the paperwork.

•If you arrive more than 15 minutes after your scheduled appointment time, we may need to reschedule your appointment.

•Your initial appointment and follow up appointments will last approximately 60 minutes.

•Please dress comfortably, as if you were going to work out at the gym. (Upper body – tank tops; Lower body – shorts.)

•If there are two (2) or more consecutive missed appointments without prior notification, then we may cancel any remaining visits and you will be referred back to your physician.

•If you need to cancel/reschedule your appointment, **please call at least 24 hours** in advance to allow us the opportunity to offer your appointment time to other patients.

•You can contact your insurance company via the "1-800" number on the back of your insurance card, if you have any questions concerning your physical therapy benefits.

Again, thank you for choosing Peacock Physical Therapy Services, LLC.

Sincerely,

PPTS Staff

PATIENT'S RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights, and responsibilities.

YOU HAVE THE *RIGHT*:
To be treated with dignity and respect
To know the names and professional status of the people serving you
To privacy
To confidentiality of your records
To receive accurate information about your health-related concerns
To know the effectiveness, possible side-effects and problems of all forms of treatment
To participate in choosing a form of treatment
To consent to, or refuse, any care of treatment
To select and/or change your health care provider
To review your medical records with your clinician
To information about services and any related costs

YOU HAVE THE *RESPONSIBILITY*:
To keep appointments or cancel in advance
To be honest about your medical history
To ask about anything you do not understand
To follow treatment advice and medical instructions
To report any significant changes in symptoms or failure to improve
To understand your insurance policy regarding physical therapy benefits
To respect clinic policies
To provide both positive and negative feedback about services and policies

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Copay, Coinsurance, & Deductible Information

•Since different plans charge different copays, coinsurances, & deductibles for physical therapy, please check with your specific insurance carrier about your benefits.

•If your insurance plan requires a deductible or coinsurance, please be ready to pay a portion of it at the time of your visit which will be applied to that day's services. We will then bill your insurance and wait for payment. If there is a remaining balance once the portion you've paid is applied and being reimbursed by your insurance carrier we will bill you.

•If your insurance plan requires a copay, we will collect that during the visit. Physical therapy is usually considered a specialty copay and **will be collected at each visit**. Acceptable forms of payment are **cash (exact amount) and credit ONLY**.

•Under certain circumstances we do offer payment plans. If you are in need of a payment plan, please speak with the billing department.

•You can contact your insurance company via the "1-800" number on the back of your insurance card, if you have any questions concerning your physical therapy benefits.

Thank you,

PPTS Staff

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Patient Information Form

NAME: ____
DATE OF BIRTH: _______/_______/________ GENDER _______________
ADDRESS:____
CITY: __________________________ STATE: _______ ZIP CODE: _____________
PHONE#:________________________ CELL PHONE: ________________________
SSN: ________________________________ MARITAL STATUS: __________________
EMPLOYER: _____________________________ PHONE#: _________________________
OCCUPATION:____

EMERGENCY CONTACT: ____
RELATIONSHIP:_______________________________ PHONE:_____________________

REFERRED BY:________________________________ PHONE:_____________________

PRIMARY INSURANCE:________________________________ PHONE:__________________
ADDRESS:____
POLICY HOLDER: ______________________ DOB: __________________
SSN: ___________________________ RELATIONSHIP:______________________________
POLICY#_________________________ GROUP#:______________
POLICY HOLDER EMPLOYER:____

SECONDARY INSURANCE:____________________________ PHONE:_______________
ADDRESS:____
POLICY HOLDER: ___________________________DOB: ______________________
SSN: _________________________ RELATIONSHIP:_____________________________
POLICY#_________________________________ GROUP#________________________
POLICY HOLDER EMPLOYER:____

ASSIGNMENT OF BENEFITS: I hereby assign all medical benefits to Peacock Physical Therapy Services, LLC. I understand that I am financially responsible for any copays, coinsurances, deductibles, and any non-covered expenses.

ASSIGNMENT TO RELEASE INFORMATON: I hereby authorize the release of any information pertinent to my case to any insurance company and/or health care professional involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

____
PATIENT SIGNATURE DATE

____
PATIENT PRINTED NAME

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Patient Medical History Form

Name:____ DOB:__________________________
Date of Injury/Exacerbation: ____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Patient Medical History: Please circle any condition for which you have received treatment. Items not circled are understood to be negative.

High Blood Pressure	Asthma	Sudden/Unexplained Weight Loss/ Gain
Obesity	Emphysema	Thyroid Problem (Hyper or Hypo)
Abnormal Heart Rate	Chronic Lung Problem	Diabetes (Type_________________)
Pacemaker/Defibrillator	Chronic Heartburn	Cancer (Type___________________)
Heart Palpitations	History of Gastric Ulcers	Epilepsy/ Seizure
Angina (chest pain)	High Cholesterol	Heart Murmur/Atrial Fibrillation
Bowl or Bladder Problems	Abnormal Bleeding	AIDS/HIV Positive

Other:____

Do you have a history of fractures?	YES	NO	Where?____
Do you have a history of back/ neck pain?	YES	NO	When?____
Do you have any metal implants?	YES	NO	Where?____
Do you smoke?	YES	NO	How much per day? ___________________________________
Do you exercise regularly?	YES	NO	How often?_______________________________________
Do you have known drug allergies?	YES	NO	Please list____
Are you pregnant or suspect pregnancy?	YES	NO	

In regards to your current pain today…please rate your pain:	none [0-1-2-3-4-5-6-7-8-9-10] worst	
Do you have any "pins and needles" or numbness into your extremities?	YES	NO
Do you have any weakness in your arms or legs?	YES	NO
Do you have any coordination or balance problems?	YES	NO
Do you have difficulty walking?	YES	NO
Do you experience dizziness of vertigo with a change in position?	YES	NO
Have you experienced headaches as a result of you condition?	YES	NO
Were you injured in a work related or auto incident?	YES	NO

Please list all current medications : (Disregard if you have a copy of medication list)
____

Please list all surgeries/ dates: (Pertinent to today's visit)
____

Please check diagnostic tests performed:
[ ] X-ray [ ] MRI [ ] CT Scan [ ] Bone scan [ ] Bone Density [ ] EMG [ ] Ultrasound

Please describe your chief complaint and current condition:
____

I believe all information to be true and complete.

Signature ____ Date ___________________________________

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Consent to Care and Treatment

PATIENT NAME____

I agree to be responsible for any portion of my bill not covered by insurance. I understand and accept the responsibility of checking on my insurance benefits and complying with those requirements. All copays, deductibles, and coinsurances are required in cash or credit at time services rendered. I hereby consent to have treatment of physical therapy. I authorize my insurance company to pay directly to PPTS. I authorize the release of medical records to my insurance company upon written request. If my account has an outstanding balance over 30 days, I will be charged 10% of the balance per month as a late fee for every month my account remains outstanding. Insurance companies will not cover these additional charges. I have completed the patient information truthfully, and have read and understand the above statements. The undersigned acknowledges that our Notice of Privacy Practices has been made available.

____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) DATE

Missed Appointment Policy

PATIENT NAME____

Peacock Physical Therapy Services, LLC (PPTS) reserves the right to charge $50.00 for missed appointments or appointments cancelled without a 24 hour notice. PPTS also reserves the right to discharge any patient, for any reason, including cancelling and not showing for appointments.

____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN) DATE

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Peacock Physical Therapy Services, LLC

Patient Privacy Policy
Patient Consent for Use and Disclosure of Protected Health Information

The Notice of Privacy Practices provided by Peacock Physical Therapy Services, LLC (PPTS) describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. PPTS reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PPTS. I hereby give my consent for PPTS to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). With this consent, PPTS may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PPTS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." With this consent, PPTS may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Patient Rights
You have certain rights under the federal privacy standards. These rights 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

Requests to inspect protected health information
As permitted by federal regulation, we require that requests to inspect or copy your health information be submitted in writing. You may obtain a form to request access to your records by contacting us. Please be aware the law allows a $22.88 processing fee plus a $0.76 per-page copy fee for copies of your medical records along with the actual cost of postage if applicable.

I have the right to request that PPTS restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. Concerns or complaints should be submitted to Peacock Physical Therapy Services, LLC.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PPTS may decline to provide treatment to me.

By signing this form, I am consenting to allow PPTS to use and disclose my PHI to carry out TPO.

____

Signature of Patient or Personal Representative Date

____

Printed Name of Patient or Personal Representative