



11813 Park Waldorf Lane #522 Phone: 240-718-8103
Waldorf, MD 20601 Fax: 240-523-8728
P.O. Box 1066 Email: ppts@peacockpts.com
Waldorf, MD 20604 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 Names & Dosages (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.

Healing one body at a time to enhance wellness over a lifetime



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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

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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. You are responsible for any remaining/outstanding balances once all applicable monies have been applied.**

• **If your insurance plan requires a copay, we will collect that prior to services rendered. Physical therapy is usually considered a specialty copay and will be collected at each visit.**

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

• **Acceptable forms of payment are cash (exact amount) ONLY. No personal checks will be accepted.**

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 INFORMATION: 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 or 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.

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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

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