peak performance
PHYSICAL THERAPY

60 S. Washington St. Greencastle, PA 17225 Phone: 717-643-0574

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Social Security Number: _____

City:_____ Home Phone: _____

State:_____ Zip Code:_____ Cell Phone:_____

Email Address:_____ Work Phone:_____

Emergency Contact Name/ Phone Number:_____

Who is your primary care physician?_____

What is the name of the physician who referred you to our care if different from above?

_____

Is this a motor vehicle accident related injury? Yes No Is this a work related injury? Yes No

- I have read the estimation of benefits from my insurance company and understand my responsibility. I agree and will be fully responsible for payment of services.
- I consent to rehabilitation and related services at Peak Performance PT. In doing so I understand, acknowledge and affirm that such rehab may involve bodily contact, touching and/or direct contact of sensitive nature.
- I, as a parent/guardian of a minor receiving treatment, do agree and understand that I have been advised to remain on the premises during all treatments, and waive any claim I may have resulting from failure to do so.
- I know and agree that Peak Performance PT is not responsible for loss or damage to personal valuables.
- I hereby assign all the benefits directly to Peak Performance PT and authorize the release of any medical records necessary to facilitate my treatment to process medical claims. I understand fully that in the event that my medical insurance neglects to pay for the services I receive, I will be financially responsible for payment.
- I acknowledge the receipt of Notice of Privacy Practices.
- I hereby release, discharge and acquit Peak Performance PT, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, 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, EMT, physician or urgent care services.

Patient/ Guardian Signature:_____ Date:_____