Peacock
Physical Therapy Services, LLC

Information Packet

Obtain or complete the following and bring with you:

☐ Referral Form from your Physician (if applicable)

☐ Patient Questionnaire

☐ Physical Therapy Medical Consent Form

☐ Patients Rights/Responsibility Consent Form

☐ Wear/bring comfortable clothing like going to a gym

☐ If seeing Physical Therapy for lower leg problem please wear/bring shorts

☐ Insurance Card

☐ Picture Identification

Most insurance carriers require a co-pay 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 your insurance card if you have any questions about your physical therapy benefits.

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

Physical Therapy New Patient Information

Welcome to Peacock Physical Therapy Services! We appreciate the opportunity to treat you.

There are a few things that you need to know to make your appointment run smoothly.

• Please remember to bring your referral/prescription and any other information your physician gave 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 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 workout at a gym. (If you are being seen for a lower leg problem, please wear/bring shorts.)

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

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

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

Again, thank you for choosing Peacock Physical Therapy Services.

Sincerely,

PPTS Staff

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

Peacock Physical Therapy Services
SUMMARY OF BASIC 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

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

Peacock Physical Therapy Services
Co-pay Information

• Since different plans charge different co-pays for physical therapy, please check with your specific policy about benefits.

• If your insurance plan requires a deductible or coinsurance, please be ready to pay a portion of it at time of visit. We will then bill your insurance and bill you the remaining balance should you have one once the portion you've paid at time of visit is applied.

• If your insurance plan requires a co-pay, we will collect that during the visit. Co-pays are usually the ***specialty co-pay*** 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.

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

Thank you,

PPTS Staff

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

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 co-payments, deductibles, and 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 DATE

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

Peacock
Physical Therapy Services, LLC

Patient Medical History Form

Name:_____DOB:_____
Date of Injury: _____

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	Recent	Weight Loss/ Gain
Heart Problem	Emphysema		Thyroid Problem (Hyper or Hypo)
Abnormal Heart Rate	Chronic Lung Problem		Diabetes (medical dependent? _____)
Pacemaker	Chronic Heartburn		Cancer (where?_____)
Heart Palpitations	History of Ulcers		Epilepsy/ Seizure
Angina (chest pain)	High Cholesterol		
Heart Murmur	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 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 in 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 incident? YES NO

Please list all current medications :
_____
_____

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

Please list all surgeries/ dates:

_____

_____

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 _____

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

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, which was prescribed by my physician. 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 1.5% per month finance charge. 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

11750 Business Park Drive, Suite 203 Waldorf, MD 20601
P. O. Box 1066 Waldorf, MD 20604
Phone: 240-718-8103 • Fax: 443-729-0619

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

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 received 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 $10 clerical fee plus a per-page copy fee for copies of your medical record.

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