Sports Physical Therapy

PEAK ENERGY
Performance Therapy, P.C.

PATIENT INFORMATION

Patient Name: Date of Birth:

Parent/Guardian Name(s):

Patient Address:

City: State: Zip:

Home Ph: Cell Ph: Text msg: yes ☐ no ☐

Email (for Peak Energy questions/scheduling/billing only) :

How did you hear about us?: Reason for treatment/area(s) of pain:

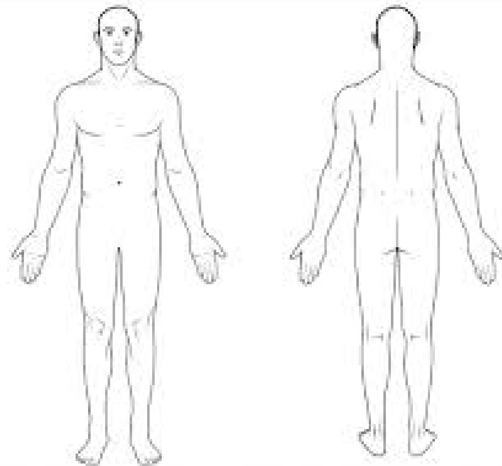
Sport(s): Position(s):

MEDICAL INFORMATION

Referring Doctor (if applicable): Office Name:

Date of Injury: Date of Surgery:

Please indicate with an 'X' any areas of pain or discomfort on the diagram.



PLEASE READ AND INITIAL EACH OFFICE POLICY

____$60 Treatment Rate is due at time of service

____I will submit my physical therapy receipts to my insurance company if I would like to be reimbursed and I understand that Peak Energy Performance Therapy is an out-of-network provider.

____A $5 monthly rebill charge is added to patient balances which are 30 days past due

____A $25 fee will be added for any returned checks.

____I agree to pay the $60 session cost if an appointment is missed or cancelled within 24 hours.

____If this account goes to collections, I will be responsible for all fees incurred.

Signature: Date: