PEAK ENERGY
Performance Therapy, P.C.

PATIENT INFORMATION

Patient Name:		Date of Birth:	
Parent/Guardian Name(s):			
Patient Address:			
City:	State:	Zip:	
Home Ph:	Work Ph:	Cell Ph:	Text msg: Y N
Email (for Peak Energy questions/scheduling only) :			
How did you hear about us?:			
Reason for treatment/area(s) of pain or discomfort:			

MEDICAL INFORMATION

Referring Doctor (if applicable):	Office Name:
Date of Injury:	Date of Surgery:

BILLING INFORMATION

Although coverage/payment is not guaranteed, would you like us to submit claims to your insurance company?	
Insurance Type:	
Insurance Company:	ID #:
Name of Primary Insured:	Primary Insured's Date of Birth:
Primary Insured's Social Security Number (only needed if ID# is not listed on insurance card):	
Specialist Co-pay:	

- I authorize the release of information necessary to process my insurance claims and for payment to be made directly to Peak Energy Performance Therapy
- I agree to pay all co-payments required, deductibles and any unpaid insurance portion below the minimum office visit rate
- I agree to immediately sign over, or pay like amount of, any insurance checks that are paid directly to me or the insured, for services rendered at Peak Energy Performance Therapy
- If this account goes to collections, I will be responsible for all fees incurred
- 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 a $25 cancellation fee if an appointment is missed or cancelled within 24 hours

Signature:	Date: