Summit Strength Physical Therapy, LLC

PATIENT PERSONAL INFORMATION

Today's Date_____

Name_____Birthdate_____

Home Address_____
(Street) (City) (State) (Zip)

Home Phone #_____Y / N Cell Phone #_____Y / N
Message OK? Message OK?

Social Security #_____ (Male Female)

Email Address_____

(Married Single Divorced Widowed Minor)

Employer_____Occupation_____

Employer Address_____ Phone #_____Y / N
Message OK?

_____

EMERGENCY CONTACT (Relationship) (Phone)

INJURY? *No _____ -or YES-date _____ Auto _____ Work_____ Other _____*

How did you hear about us? Prior Patient ___ Doctor ___ Friend (Name) _____ Other _____

PERSON RESPONSIBLE FOR ACCOUNT **CHECK BOX IF SAME AS ABOVE** ☐

Name_____Address_____

Relationship to client_____Birthdate_____

Social Security #_____ Phone #_____

Employer_____ Address_____Phone #_____

Spouse's Name_____ Birthdate_____ Social Security #_____

Address_____ Phone #_____

Spouse's
Employer_____Phone#_____

Address_____

Summit Strength Physical Therapy, LLC

Agreement to Treat, Assignment and Release, Agreement of Privacy (HIPAA), Cancellation Policy

I/we hereby authorize to receive care at Summit Strength Physical Therapy, LLC. I/we understand that receiving physical therapy or strength and conditioning may involve stress of musculoskeletal tissue that may cause soreness (like one might feel for a few days after starting a workout program such as running or lifting weights.) Furthermore, I/we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, blood flow restriction, dry needling, compression, ice, heat, taping, bracing, orthotic fitting, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions. I, the undersigned, assign directly to Summit Strength Physical Therapy, LLC all medical benefits, if any, otherwise payable to me for services rendered. I further understand and agree that I am ultimately responsible for the full payment of all treatment provided by Summit Strength Physical Therapy, LLC. This responsibility applies at the time of service, regardless of whether payment is expected from health insurance, workers' compensation, automobile insurance, general liability insurance, or any other third-party payer. If, before, during, or after my course of treatment, I, or the insurance carrier, employer, or liability insurer changes, denies, or reclassifies coverage or at-fault status, I remain personally responsible for all charges, including any amounts not paid by my insurer or recouped by the insurer after initial payment. To avoid recoupment or unpaid balances, I agree to pay at the time of service. If my insurer or liability carrier later seeks repayment (recoupment) from Summit Strength Physical Therapy, LLC, I agree to reimburse the clinic for any such amounts, and this balance will become immediately due. I hereby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that payment will be due at the time of service for estimated costs not covered by insurance. I acknowledge that I have reviewed Summit Strength Physical Therapy, LLC's Notice of Privacy Practices (HIPAA) on our waiting room wall or at SummitStrength.com. We may charge you $50.00 on your account for a late cancellation or no show. You may also lose any prior scheduling arrangements (Preferred Continuous Time Slots) that are made.

Signature_____ Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare and/or Medigap benefits be made on my behalf to Summit Strength Physical Therapy, LLC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. My signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that in Medicare-assigned cases, the provider agrees to accept the Medicare allowable charge. I am responsible for the deductible, coinsurance, non-covered services, and any balances not paid by Medicare or secondary insurance**.** I further understand that if Medicare or any secondary insurance carrier later recoups (takes back) payment for services already rendered, I will remain financially responsible for the recouped amount and agree that Summit Strength Physical Therapy, LLC may bill my account or charge my payment method on file for such balances.

Signature_____ Date_____

Summit Strength Physical Therapy, LLC

CONFIDENTIAL HEALTH HISTORY

Patient Name: ________

Referring Physician: _____ Primary Care Physician: _____

Are you aware of your diagnosis? _____

Have you had any other orthopedic injuries or surgeries? If yes, explain _____

Have you had any prior physical or speech therapy visits this year? If yes, how many visits? _____

At the present time, would you rate your overall general health as:

Excellent ____ Good ____ Fair ____ Poor_____

Please circle all conditions that you currently have or have had in the past:

MUSCULOSKELTAL
Osteoarthritis
Osteopenia
Osteoporosis
Rheumatoid Arthritis
Lupus/SLE
Fibromyalgia
Headaches/Migraines
Bulging Disk
Leg Cramps/Restless Legs
Jaw Pain/TMJ
History of Falling
Use of Cane/Walker
Gout
Other:

CIRCULATION/RESPIRATORY
Heart Disease
Heart Surgery
Heart Arrhythmia
Pacemaker
Myocardial Infarction
Angina/Chest Pain
Mitral Valve Prolapse
Aneurysm
High/Low Blood Pressure
High Cholesterol-On Statin Meds
Anemia
Blood Clots/Phlebitis
Asthma/Shortness of breath
COPD
Other:

ENDOCRINE/DIGESTION
Diabetes
Low Blood Sugar
Kidney Dysfunction
Irritable Bowel Syndrome
Crohn's Disease
Bladder Dysfunction
Unexplained weight loss/gain
Thyroid Dysfunction
Hernia
Other:

NERVOUS SYSTEM
Stroke/TIA
Polio
Parkinson's Disease
Multiple Sclerosis
Epilepsy/Seizures
Concussion
Traumatic Brain Injury
Numbness or Tingling
Other:

CANCER
Type of Cancer:
Treatment:
Date of Diagnosis:

INFECTIOUS DISEASES
STD
AIDS/HIV
Blood transfusion
Shingles
Tuberculosis
Hepatitis
Influenza
Other:

OTHER:
Pregnant
Breastfeeding
Alcohol consumption
Smoking
Recent hospitalizations

Is there anything else we should know about your health? _____

Condition Information ***Name:***_____

When did you first notice the pain or have functional problems due to the condition/injury? _____

First episode_____ Most Recent Episode _____

How did your symptoms/injury occur? _____

Where are your symptoms located? _____

What is your main problem related to this condition? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had any surgery for your injury/condition?_____ If yes, what kind and when? _____

Have you received any injections for your injury/condition?_____ If yes, when?_____ Did it help? _____

Diagnostic tests performed (X-RAY, MRI, etc) _____

For your current injury or condition, have you seen any of the following? (Please check all that apply)

Medical Doctor □ Physical Therapist □ Chiropractor □ Psychiatrist/Psychologist □ Personal Trainer □

Athletic Trainer □ Massage Therapist □ Other □

Are you exercising? _____ Describe: _____

Problems with exercise? _____ Describe: _____

What do you hope to accomplish with physical therapy? _____

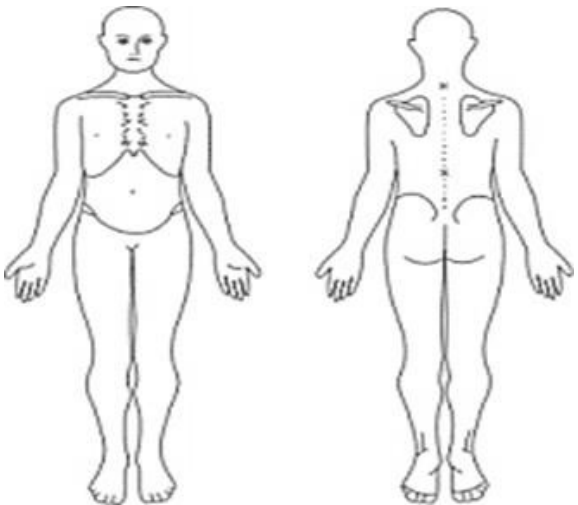
How often do you experience your current symptoms? Always □ Sometimes □

Are your symptoms? Unchanged □ Improving □ Worsening □

Pain severity: Mild □ Moderate □ Severe □

Functional limitation: Mild □ Moderate □ Severe □

On the diagram, please indicate your current symptom location below:



Summit Strength Physical Therapy, LLC

MEDICATION LIST (we can scan a copy of your list)

Patient Name: _____ _____

Food/Drug Allergies: _____

Latex Allergy/Other Allergies: _____

Have you ever treated your symptoms with non-prescribed pain medication: Y/N

Name of Medication:	***Dosage:***	***How Often Taken:***	***Comments:***
Prescriptions			
Pain Management **i.e. marijuana, alcohol, other**			
Vitamins & Over the Counter			

YELLOW FLAG RISK FORM SUMMIT STRENGTH PHYSICAL THERAPY

Name: Primary Complaint:_____

1. Please indicate your usual level of pain during **the past week**.

No Pain **Worst pain possible**

0 1 2 3 4 5 6 7 8 9 10

2. Does pain, numbness, tingling, or weakness, extend into your leg (from back) &/or arm (from neck)?

None of the time **All of the time**

0 1 2 3 4 5 6 7 8 9 10

3. How would you rate **your general health**?

Poor **Excellent**

0 1 2 3 4 5 6 7 8 9 10

4. f you had to spend the rest of your life with your condition as it is right now. How would you feel about it?

Delighted **Terrible**

0 1 2 3 4 5 6 7 8 9 10

5. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) have you been feeling **during the past week**?

Not at all **Extremely anxious**

0 1 2 3 4 5 6 7 8 9 10

6. How much have you been able to control (Reduce / help) your pain / complaint on your own during **the past week**?

I can reduce it **I can't reduce it at all**

0 1 2 3 4 5 6 7 8 9 10

7. Please indicate how depressed (eg. down in dumps, sad, downhearted, in low spirits, pessimistic feelings of hopelessness) have you been feeling in **the past week**.

Not depressed at all **Extremely depressed**

0 1 2 3 4 5 6 7 8 9 10

8. On a scale of 0-10, how certain are you that you will be doing normal activities or working in **six months**?

Very certain **Not certain at all**

0 1 2 3 4 5 6 7 8 9 10

9. I can do light work for an hour.

Completely agree **Completely disagree**

0 1 2 3 4 5 6 7 8 9 10

10. I can sleep at night.

Completely agree **Completely disagree**

0 1 2 3 4 5 6 7 8 9 10

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely disagree **Completely agree**

0 1 2 3 4 5 6 7 8 9 10

12. Physical activity makes my pain worse.

Completely disagree **Completely agree**

0 1 2 3 4 5 6 7 8 9 10

13. I should not do my normal activities including work, with my present pain.

Completely disagree **Completely agree**

0 1 2 3 4 5 6 7 8 9 1

Summit Strength Physical Therapy
Lee's Summit & Blue Springs
www.summitstrength.com
Phone: 816-524-7040

Printed Name
Date of Birth
Address

Assignment Of Insurance Benefits and Verification

The administrative burden of running a business with today's governmental, legal, and insurance reimbursement environments can create challenges in securing full payment for your care. Please know that we fight for every dollar on your behalf and will promptly reimburse you for any overpayments you make. We obtain insurance approvals, file claims in a timely manner, and fully document all conversations and correspondence to prove that your claim should be paid. Unfortunately, payers often deny, delay, or recoup payments in order to protect their own profits. At times, **after attempts of appeal**, and despite our thorough documentation, large insurance companies may still refuse to allocate resources to address our requests. In these cases, we may encounter **Unresponsive Payer Administrative Cost Transfer**. When this occurs, you, your employer, adjuster or lawyer will have the responsibility to continue pursuing payment with your insurer.

Insurance Company: _____ Phone: _____

Policy Number: _____ Group Number: _____ In Out Network

Deductible: _____ Copay: _____

Coinsurance _____ Out of Pocket: _____

Out of pocket: _____

Visit Max _____ Processed to date: _____ Auth Required: _____ Referral Req _____

Notes_____

Secondary Insurance Company: _____ Phone: _____

Policy Number: _____ Group Number: _____ In Out Network

Deductible: _____ Copay: _____

Coinsurance: _____ Out of Pocket: _____

Out of pocket: _____

Visit Max _____ Used_____ Auth Required _____ Referral Req

Notes_____

Advance payment toward scheduling administration, projected charges, and outstanding balances: **$_____**
$200 Initial Evaluation $150 per 1-hour visit

This payment will be applied toward deductible and copayment responsibilities. You will receive a monthly statement, and your card will be billed at least once monthly for estimated costs.

Cardholder Name: _____
Email (for receipts): _____
Credit Card Type: ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover
Card Number: _____

Expiration Date: _____ **CVV:** _____

Authorization: I authorize Summit Strength Physical Therapy, LLC to charge my card for patient balances and understand I am fully responsible for knowing and managing my insurance benefits, including deductibles, co-insurance, visit limits, denied care and recoupments.
Signature: _____ Date: _____

Summit Strength Physical Therapy LLC
Notice of Privacy Practices

Effective Date: September 1, 2025

Phone: 816-524-7040 | Fax: 816-524-7057
800 NW Main Street, Lee's Summit, MO 64086
1300 NW 7 State Route 7, Blue Springs, MO 64014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

- Get a copy of your paper or electronic medical record
- Request corrections to your medical record
- Request confidential communication
- Ask us to limit what we use or share
- Obtain a list of those with whom we've shared your information
- Receive a copy of this privacy notice
- Choose someone to act for you (e.g., legal guardian, medical power of attorney)
- File a complaint if you believe your privacy rights have been violated
- Request access to your health records as required by the 21st Century Cures Act
- Be notified of any unauthorized access, use, or disclosure of your protected health information (PHI)

Your Choices

- Share information with family, friends, or others involved in your care
- Share information in a disaster relief situation
- If you are unable to communicate your preferences (e.g., unconscious), we may share your information if we believe it is in your best interest.

We Will Never

- Sell your information
- Share your information for marketing purposes without your written permission
- Use or disclose notes without your authorization (if applicable)

Our Uses and Disclosures

- Treatment - We can use your health information and share it with other professionals who are treating you.
- Operations - We use your information to run our practice, improve services, and manage care coordination.
- Payment - We can use and share your health information to bill and receive payment from health plans or other entities.

Additional Ways We May Share Your Information

- Help with public health and safety issues: prevent disease, report abuse/neglect/domestic violence, report adverse reactions or recalls, prevent/reduce serious threats to health or safety.
- Comply with federal or state laws: HHS investigations, workers' comp claims, law enforcement/legal requests, health oversight agencies, military/national security functions, court/administrative orders, subpoenas, or legal proceedings.

Our Responsibilities

- We are required by law to protect your health information.
- We will inform you promptly if a breach occurs that may compromise your data.
- We must follow the terms of this notice and provide you with a copy.
- We will only use or share your information as described in this notice unless you provide written authorization. You may revoke this authorization at any time in writing.

Changes to This Notice

- We reserve the right to change this notice. Updates will apply to all your health information we maintain, and the updated notice will be available:
- Upon request
- At our office locations
- On our website (if applicable)

Questions or Complaints?

- If you have questions or believe your rights have been violated, you can contact:
- Summit Strength Physical Therapy LLC, Phone: 816-524-7040
- You may also file a complaint with the U.S. Department of Health and Human Services:

  Office for Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  Phone: 1-877-696-6775
  www.hhs.gov/ocr/privacy/hipaa/complaints