Alliance Physcial Therapy

PATIENT/PROVIDER/INJURY INFORMATION

Full Name (First, MI, Last, Suffix): SSN:			DOB:
Home Address (Include Apt #):	City/Town:	State:	Zip Code:
Primary Phone: ☐ Cell ☐ Home ☐ Other	Secondary Phone: ☐Cell ☐Home ☐Other	Sex: M F	Reason for Referral (DX)
Email Address:	Preferred Method for Reminders (circle one): Phone - Primary Secondary Text - Primary Secondary No Reminder		How did you hear about us?:
Referring Provider:	Primary Care Provider:		Is the Injury related to (circle one): Work Auto Accident Neither
Emergency Contact Name:	Emergency Contact Number:		Emergency Contact Relationship:

EMPLOYER INFORMATION

Employer Name:	Occupation:	Work Phone:

PRIMARY INSURANCE INFORMATION

Insurance Name / ID Number:	Policy Holder Full Name (First, MI, Last, Suffix): ☐ Spouse ☐ Parent ☐ Other		Policy Holder DOB:
Policy Holder Street Address (only if different):	City/Town:	State:	Zip Code:
Policy Holder Phone Number:	Policy Holder Employer:	Is the Policy Holder a RETIRED Federal Employee?: YES NO	

SECONDARY INSURANCE INFORMATION

Insurance Name:	Policy Holder Full Name (First, MI, Last, Suffix): ☐ Spouse ☐ Parent ☐ Other		Policy Holder DOB:
Policy Holder Street Address (only if different):	City/Town:	State:	Zip Code:
Policy Holder Phone Number:	Policy Holder Employer:	Is the Policy Holder a RETIRED Federal Employee?: YES NO	

WORKER'S COMPENSATION/AUTO CARRIER/ATTORNEY INFORMATION (LOP NEEDED)

Worker's Comp, Auto Carrier or Attorney Name:	Worker's Comp, Auto Carrier or Attorney Billing Address:	
Claim Number:	Contact Name & Phone Number:	Date and State of Injury:

IMPORTANT: Please note that when/if Worker's Compensation or Auto Benefits deny or exhaust, remaining bills will be forwarded to the health insurance provided or to the patient/guarantor, whichever is applicable.

FINANCIALLY RESPONSIBLE PARTY/GUARANTOR-OTHER THAN PATIENT OR INSURANCE

Full Name (First, MI, Last, Suffix):			Relation to Patient:
Home Address (Include Apt #):	City/Town:	State:	Zip Code:
Primary Phone: ☐ Cell ☐ Home ☐ Other	Privacy Policy Exclusion: Is there anyone we are NOT ALLOWED to speak to about your care or account? _____		

By Signing below I acknowlege that all of the above information is true and accurate. If at anytime any of this information changes, I am aware that I must inform the facility immediately

Patient/Guardian: **Date:**	**Photo ID checked by:**

Alliance Physical Therapy

☐ **CONSENT FOR CARE AND TREATMENT**

I, the undersigned, give my consent for Alliance Physical Therapy/Pinnacle Rehabilitation Network LLC to furnish medical care and treatment to, _____,considered necessary and proper in diagnosing or treating his/her physical condition.

_____ **Patient/Guardian Initials**

☐ **PRIVACY NOTICE**

A copy of our Privacy Notice, which describes how your medical/account information may be used and disclosed, has been offered to you. PLEASE REVIEW IT CAREFULLY and let us know if there are any exceptions.

_____ **Patient/Guardian Initials**

☐ **CANCELLATION/NO SHOW POLICY**

If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient.

_____ **Patient/Guardian Initials**

☐ **FINANCIAL POLICY STATEMENT**

- We have provided you the verification of benefits of your insurance coverage.
- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Alliance Physical Therapy/Pinnacle Rehabilitation Network LLC
- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus the banks returned check fee.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to collection agency fees, court costs and attorneys' fees in the amount of thirty-three percent (33%) of the total indebtedness, which may include but is not limited to all court costs and filing fees incurred by Alliance Physical Therapy/Pinnacle Rehabilitation Network LLC.
- I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.

_____**Patient/Guardian Initials**

☐ **BENEFIT ASSIGNMENT**

I hereby assign all medical benefits to include major medical benefits to which I am entitled for these services including Medicare, Medigap, Medicaid, private insurance and third party payors to Alliance Physical Therapy/Pinnacle Rehabilitation Network LLC

_____**Patient/Guardian Initials**

Patient/Guardian Signature: _____ **Date** _____

Printed Name: _____

Facility: _____

MEDICAL HISTORY Pg 1
PT OT

Patient Name _____ Subscriber ID # _____ Primary Language _____

DOB: _____

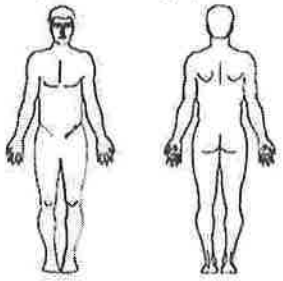
Describe Your Current Problem and How It Began _____

_____

_____

Onset date/Surgery date _____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date) _____
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain) _____
_____
☐ Osteoporosis
☐ Other Health Problems (Explain) _____
_____

☐ Numbness /Weakness (Location) _____
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries _____
more space see page 2
☐ Tobacco Use - Type _____
Frequency _____ /Day
☐ Current Medications see page 2 _____
_____

Who have you seen for your condition before today? ☐ NoOne

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other _____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when? _____

What is your occupation? _____

Medical History Page 2

Last name: _____ First Name: _____ D.O.B. _____

Allergies: Are you latex sensitive? ☐yes ☐ no List any other allergies:_____

_____

Do you have a pace maker or medical implant? ☐ yes ☐ no

SURGERIES (cont from page 1):

Include Date Reason for Surgeries:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc). You may attach a copy of your own list of medications if available.

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature_____**Date**_____

Reviewed with Patient: _____ **Date:** _____