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. Failure to provide 24 hours' notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $40.00 charge.

_____ **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 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.
- When paying by credit card, I understand that the credit card processor Zirmed Inc. stores the credit card information securely. This credit card information may be used for future payments. If at any time, I want to reverse this I need to inform the facility in writing.
- 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: ______________

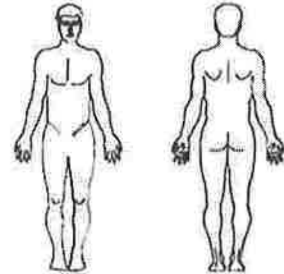
Describe Your Current Problem and How It Began ______________________

____

____

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? ☐ No One
☐ 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. _______ ____________________________ 4. _______ ____________________________
2. _______ ____________________________ 5. _______ ____________________________
3. _______ ____________________________ 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: ________
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Medication: ____________________________
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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:** ____________________