Alliance Physical 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: ☐ell ☐ome ☐ther	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? _____ Or Other Exclusions? _____		

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:**

☐ **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 has been offered to you. This describes how your personal medical information may be used, disclosed, and communicated which may include email or text. PLEASE REVIEW IT CAREFULLY and let us know if you require 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: _____

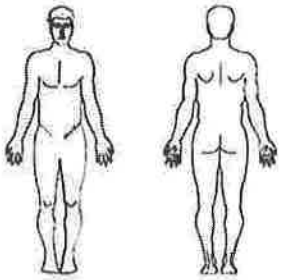
Describe Your Current Problem and How It Began_____

_____

_____

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. _____ _____
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: _____
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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:** _____