Alliance Physical Therapy / Pinnacle Rehabilitation Network, LLC

Patient Information

Patient's Name: _____ DOB: _____ SSN: _____ Sex: M F

Mailing Address: _____ City/State/Zip: _____

Primary PH#: _____ Cell ☐ Home ☐ Other ☐ Secondary PH#: _____ Cell ☐ Home ☐ Other ☐

Preferred Method for Reminders (Circle One): **Call:** Primary/ Secondary **Text:** Primary /Secondary **No Reminder**

Email: _____ How did you hear about us? _____

Emergency Contact: Name _____ PH# _____ Relationship: _____

Reason for Referral: _____ Is the injury related to (circle one): Work/Auto /Neither

Referring Provider: _____ Primary Care Provider: _____

Primary Insurance

Insurance: _____ ID# _____ **Is the Policy Holder a RETIRED Federal Employee:** Yes/No

Policy Holder: Name: _____ Relationship to Insured: _____ DOB: _____

Street Address: _____ City/State/Zip: _____ PH#: _____

Secondary Insurance

Insurance: _____ ID# _____ **Is the Policy Holder a RETIRED Federal Employee:** Yes/No

Policy Holder: Name: _____ Relationship to Insured: _____ DOB: _____

Street Address: _____ City/State/Zip: _____ PH#: _____

Workers Compensation/Auto Carrier

Worker's Comp/Auto Carrier: _____ Claim Number: _____

Contact Name: _____ Contact Phone Number: _____

Employer: _____ PH#: _____

IMPORTANT: For an auto accident, we can only send claims to the insurance company of the car you were in at the time of the accident; we cannot send claims to the insurance company of the other party involved. Do not provide insurance company of other party involved.

Attorney Information

Contact Name: _____ Contact PH#: _____ Contact Fax#: _____

Financially Responsible Party/Guarantor-Other Than Patient or Insurance

Name: _____ PH#: _____

Street Address: _____ City/State/Zip: _____

By signing below I acknowledge that all of the above information is true and accurate.
If at any time 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 /Pinnacle Rehabilitation Network, LLC ("Pinnacle")

☐ **CONSENT FOR CARE AND TREATMENT**

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

☐ **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.

Privacy Policy Exclusion: I request the following restrictions (N/A if no restrictions) _____

☐ **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.

☐ **FINANCIAL POLICY STATEMENT**

- We have provided you the verification of benefits of your insurance coverage.
- I understand that if any changes are made to my personal or insurance information it is my responsibility to inform the facility immediately of said changes to avoid unnecessary patient balances.
- When/if Workers Compensation or Auto benefits deny or exhaust, remaining bills will be forwarded to the health insurance provided or to the patient/guarantor.
- 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".
- Any allowed charges not covered by your insurance will be your responsibility.
- 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 will be used for future payments and final payment when all claims are processed. **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 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 "Pinnacle".

☐ **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 "Pinnacle".

I acknowledge that by signing this document I have read and understand the above and I have received a copy of this form.

Patient/Guardian Signature: _____ **DOB:** _____

Printed Name: _____ **Date:** _____

Facility: _____

MEDICAL HISTORY Pg 1
PT OT

Patient Name_____ Subscriber ID #_____ Primary Language_____

DOB: _____

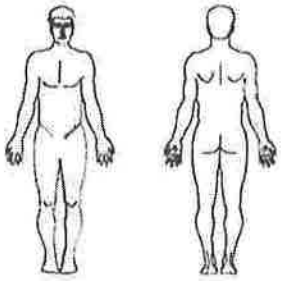
Describe Your Current Problem and How It Began_____

_____

_____

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: _____
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:** _____