Reason for Visit: _______________________________________ INJURY/SX DATE_________

**PATIENT INFORMATION**

TODAY'S DATE ______________ EVALUATION DATE_________

NAME: ___________________________________________________________ MALE FEMALE (circle one)

Address: _________________________________________City:_______________ Zip:____________

Home Phone: ____________________ Cell phone: __________________________________

Email: _________________________________ DOCTOR/REFERRAL SOURCE: ______________________

DOB: ____/____/_____ SOCIAL SECURITY NUMBER: _____/____/______

IN CASE OF EMERGENCY, NOTIFY: ____________________________________PHONE: ____________________

**Is this due to a car accident or work injury?** ____________________________________________________

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**: _________________________________ MEMBER ID: ____________________________

GROUP NUMBER: _______________________________ PRIMARY INS. PHONE NUMBER: __________________

POLICY HOLDER: ____________________________________RELATIONSHIP TO PATIENT: __________________

IF OTHER THAN PATIENT, POLICY HOLDER'S SOCIAL SECURITY NUMBER: ____/___/_____ DOB: ____/____/____

EMPLOYER: ______________________________________________ EMPLOYER'S PHONE: _________________

**SECONDARY INSURANCE**: _________________________________ MEMBER ID: ____________________________

GROUP NUMBER: _______________________________ PRIMARY INS. PHONE NUMBER: __________________

POLICY HOLDER: ____________________________________RELATIONSHIP TO PATIENT: __________________

IF OTHER THAN PATIENT, POLICY HOLDER'S SOCIAL SECURITY NUMBER: ____/___/_____ DOB: ____/____/____

EMPLOYER: ______________________________________________ EMPLOYER'S PHONE: _________________

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**AUTHORIZATION FOR TREATMENT:** I give my consent to undergo examination and treatment by the staff a **Pinnacle Physical Therapy.**

PATIENT SIGNATURE: ______________________________________________________ DATE: ________________________________

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**AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS:** I authorize the release of any information required to act on this claim and permit photographic or further facsimile reproduction of this authorization to be used in place of the original. I hereby assign to JR Watts, Brandon Young, DBA Pinnacle Physical Therapy & Personal Training, LLC the medical benefits I am entitled to for Physical Therapy service from my insurance company. **I am responsible** for any charges not paid by my insurance company. *By listing my email address and cell phone number, I authorize Pinnacle Physical Therapy to send emails and text messages to me.

PATIENT'S SIGNATURE__________________________________________________ DATE: __________________

**Medical History**

Current Medications:_______________________________________________________________________________

_______________________________________________________________________________________________

Allergies:_____________________________________________________________________________________

Have you had physical therapy before? Y N _______________________________________________________

History of surgeries: ___________________________________________________________________

___________________________________________________________________

What are your goals for Therapy?

1.___________________________________________________________________________

2.___________________________________________________________________________

3.___________________________________________________________________________

4.___________________________________________________________________________

Have you had any diagnostic tests related to this condition?

| Test/Examination | Yes | No | Date | Results |
|---|---|---|---|---|
| X-ray | | | | |
| MRI | | | | |
| Bone Scan | | | | |
| CT Scan | | | | |
| Nerve Conduction Studies | | | | |
| Electromyography | | | | |
| Ultrasound | | | | |
| Other | | | | |

High Blood Pressure Y N

Stroke Y N

Low Blood Pressure Y N

Are you diabetic Y N

History of Cancer Y N __________________________

Heart Disease Y N

C.O.P.D. Y N

Osteoporosis Y N

Bowel issues Y N

Bladder issues Y N

**New, Unusual, or atypical issues you are currently experiencing:**

Weight loss or gain Y N

Nausea, vomiting Y N

Dizziness, lightheadedness Y N

Fatigue Y N

Weakness Y N

Fever, chills, sweats Y N

Numbness or tingling Y N

Tremors Y N

Seizures Y N

Double vision Y N

Loss of Vision Y N

Eye Redness Y N

Skin rash Y N

Problems sleeping Y N

Sexual difficulties Y N

Night sweats Y N

Problems with balance Y N

Hearing problems Y N

Recent falls Y N

Joint and muscle swelling Y N

Difficulty breathing Y N

Regular cough Y N

Arm or leg swelling Y N

Heart racing Y N

Difficulty swallowing Y N

Heartburn, indigestion Y N

Constipation, diarrhea Y N

Post menopause Y N

Problems urinating Y N

Incontinence Y N

Blood in stools or urine Y N

Pregnant Y N

Stress at home or work Y N

Do you have a pacemaker? Y N ________________________________

Any previous surgeries or fractures? Y N ________________________________

Do you understand the nature of your condition? Y N ________________________________

Do you currently exercise? Y N if Yes, please describe: ____ ___________________________________

Has your doctor cleared you to exercise? Y N ________________________________

Has your doctor placed any limitations on your exercise? Y N ________________________________

What kind of exercise do you perform? ____________________________________________________________

How often do you exercise? ______________________________________________________________________

**Pinnacle Physical Therapy & Personal Training, LLC**
**Billing Information**

**Insurance**

We are in many health plans even though we may not be listed in the book as Pinnacle Physical Therapy & Personal Training, LLC and may be listed under the corporation's EIN Federal ID number.

We bill your insurance as a courtesy to you. As needed we may require you to take responsibility to work with you insurance company to help assure payment of your bills.

You will receive a statement from our office after we have heard from your insurance company. This should reflect payment made by your insurance company and your responsibility. Payment is expected within 30 days of the statement.

We pride ourselves as being high quality providers of Physical Therapy services. Insurance companies sometimes use the term "not medically necessary" as a way to deny benefits. Unless otherwise contracted, we do not accept "not medically necessary" as an excuse to not make payment. We will make every effort to collect payment from your insurance company but this does not negate your responsibility for payment.

**Clinic Name**
The Clinic name is ***Pinnacle Physical Therapy & Personal Training, LLC***.

**Attorney**
If you have an attorney, we will accept a letter of protection for outstanding balances not covered by your insurance company. If you have an attorney, we expect your cooperation in helping us collect from your insurance company. Failure to cooperate will result in us sending bills directly to you and demanding payment within 30 days. Medicaid/T19 will not be accepted as insurance in litigation cases. A letter of protection from your attorney will be required for treatment.

**Financial Hardship**
We are in the business of helping people. Should you have some difficulty paying your bills, we will work with you to help you create a payment plan that is mutually agreed upon. Finance should not limit your health care decisions. Please contact the billing department at 262-515-2035.

**Our Promise**
We promise to do our best to help your rehabilitation process on each, and every day. We will give you our best treatment available.

Please sign that you have read and received this statement:

| __________________________ | __________________________ | ____________________ |
| --- | --- | --- |
| Print Name | Signature | Date |

**Financial Responsibility Disclosure**

I understand and agree that services have been rendered **for which I am fully responsible for,** whether or not my insurance company should cover the cost of at least a portion of the services rendered. I further understand and agree that in the event that I default on any payment due and owing to Pinnacle Physical Therapy & Personal Training, LLC for such services, **I will pay any and all costs of collection** of such payments due and owing.

Agreed to as of the date signed below:

____________________________________
Signature of Patient or Legal Representative

__________________
Date

## Privacy Policy Acknowledgment

______ I understand that Pinnacle Physical Therapy will not release my information to anyone without my permission and follow rules set forth by HIPPA. (If you would like to read the full privacy policy, please ask a staff member for a copy)

## Non-covered Services Waiver

______ I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services and supplies.

## No Show/Cancellation Policy

______ The time of the therapists at Pinnacle Physical Therapy & Personal Training, LLC is valuable, as is your time. We kindly ask for a minimum of 24 hours notice for any cancellations or rescheduled appointments. We understand that sometimes it is difficult to plan for the unexpected and, therefore, we will allow leeway for the first two no show appointments.

Following two no show appointments, based on the decision by your therapist, you may either:

- Pay $30.00 per No Show (payment must be received before future appointments can be made)

  OR
- Be discharged from Physical Therapy

Please sign the bottom of this policy indication that you were made aware of our procedures including missed visits.

_______ Are you interested in natural or holistic options during your plan of care? Yes_____ No_____

Thank you

PATIENT SIGNATURE: ________________________________________________________ DATE: ________________________________

Pinnacle PT Representative Signature: ___________________________________________DATE: _________________________________