PINNACLE PHYSICAL THERAPY

www.pinnaclept.net
571 Stanislaus Street, Suite F - P O Box 637
Angels Camp, CA 95221
209-736-0956 FAX: 209-736-0958
email: dmonroy@pinnaclept.net

PATIENT LAST NAME (PLEASE PRINT) | FIRST NAME | ☐ MALE ☐ FEMALE | MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER | DATE OF BIRTH

PHYSICAL ADDRESS (NOT P.O. BOX) | CITY | STATE | ZIP CODE | SOCIAL SECURITY NUMBER

MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE | #1 PHONE NUMBER ☐ HOME ☐ CELL ☐ WORK

EMAIL | #2 PHONE NUMBER ☐ HOME ☐ CELL ☐ WORK

YOUR EMPLOYER (IF SELF, PLEASE SPECIFY BUSINESS) | BUSINESS PHONE | OCCUPATION

ADDRESS | CITY | STATE | ZIP CODE | STUDENT ☐ FULL TIME ☐ PART TIIME

NAME OF EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER

REFERRING PHYSICIAN | PHYSICIAN PHONE NUMBER | DOI OR SYMPTOMS STARTED | DATE OF SURGERY

INJURY TYPE OR DIAGNOSIS | WORK RELATED ☐ YES ☐ NO | AUTO RELATED ☐ YES STATE ☐ NO

NAME OF ADDITIONAL PRIMARY CARE PROVIDER OR OTHER PHYSICIAN TO WHOM YOU WOULD LIKE REPORTS SENT | PHONE NUMBER

INSURANCE INFORMATION

WHO MIGHT ASSIST YOU WITH PAYMENT OF FEES?

☐ PRIVATE INSURANCE ☐ MEDICARE ☐ WORKER'S COMP ☐ AUTO INSURANCE ☐ OTHER _____

PRIMARY INSURANCE CARRIER | POLICY ID | GROUP NUMBER | EFFECTIVE DATE

SECONDARY INSURANCE CARRIER | POLICY ID | GROUP NUMBER | EFFECTIVE DATE

NAME OF INSURED | RELATIONSHIP | INSURED DOB | ☐ MALE ☐ FEMALE | PHONE CONTACT NO.

INSURED'S ADDRESS | CITY | STATE | ZIP CODE | EMPLOYER

GUARANTOR | SOCIAL SECURITY NUMBER | RELATIONSHIP | PHONE NUMBER

WORKERS COMPENSATION / AUTOMOBILE INSURANCE INFORMATION

YOUR ATTORNEY | PHONE NUMBER | FAX NUMBER

ADDRESS | CITY | STATE | ZIP CODE

CLAIM NO. | ADJUSTER | # OF VISITS AUTHORIZED | PHONE NUMBER | FAX NUMBER

HOW DID YOU HEAR ABOUT US?

I attest that the above stated is true and correct

X _____ _____

Signature of Patient or Responsible Agent **Date**

ACCT#	OFFICE USE ONLY	AUTHORIZED FROM	AUTHORIZED TO	IE

Pinnacle Physical Therapy

FINANCIAL POLICY

Patients with insurance:

- We will **only** bill the insurance presented at time of service.
- It is your responsibility to know your insurance benefits. We will call your insurance company to verify your physical therapy benefits, but insurance companies only give a review of eligibility and benefit information. It is never a guarantee or promise of payment.
- You are expected to pay any **known** co-pays, applicable deductible and estimated amounts of co-insurance at the time of service.
- We require you as a patient to be responsible for any balance your insurance does not pay.
- Any balances owed must be paid within 90 days to avoid further collection activity unless other arrangements have been made with the account specialist.

Self-Pay Patients:

- Full cash payments are expected at time of service.
- We **will not** bill insurance at a later date once cash pay has been arranged.

Delinquent Accounts:

- You will receive periodic statements for outstanding balances.
- After 90 days of nonpayment on any balances owed, your account will be assessed a $15.00 fee.
- Your account may be turned over to a professional agency specializing in debt collection for continued nonpayment.
- Once your account is turned over to a collection agency for nonpayment, you will be responsible for any fees accrued by the collection agency during the collection process on your account.
- We will not be able to see you for any future appointments until **all past due fees** are paid in full.

Forms of Payment: We accept cash, checks, and Discover, Visa and MasterCard credit/debit cards. There will be a $25.00 charge on all returned checks.

I certify that I have read and agree to the Financial Policies of Pinnacle Physical Therapy.

_____

Printed Name

_____ _____

Signature **Date**

PINNACLE PHYSICAL THERAPY

571 STANISLAUS ST., SUITE F P.O BOX 637 ANGELS CAMP, CA 95221 (209) 736-0956
TAX I.D. # 20-0997774

CANCELLATION AND NO SHOW POLICY

Because your care is very important to us and the stability of the practice needs to be maintained, we must request that all patients accept a definite arrangement for appointments. Once an appointment is made, please remember **this time is reserved for you!!** A notice of appointment cancellation must be received at the clinic, no less than 24 business hours prior to the scheduled treatment to avoid a **$30 cancellation fee**. The fee is your responsibility and cannot be billed to your insurance. It must be paid before any further treatment can be provided. For your convenience, an answering machine is available 24 hours a day. Please remember that the cancellation notice will be considered received when retrieved after lunch or first thing in the morning, not the time at which the message was left. The fee may be waived under certain circumstances of extreme emergency if staff is able to fill the appointment time.

SIGNED:_____ **DATE:**_____

AUTHORIZATION TO RELEASE X-RAYS AND INFORMATION

I authorize the release of Medical Information (i.e., X-rays or other diagnostic reports) which may enhance my physical therapy care plan.

SIGNED:_____ **DATE:**_____

AUTHORIZATION FOR DIRECT PAYMENT & FINANCIAL RESPONSIBILITY

I hereby authorize the release of any information necessary to secure the payments of benefits. Also, I authorize direct payment of insurance benefits to this medical office. A photo copy of this signature is valid as the original (**Under California State Insurance Code #10133**) I understand that I am financially responsible for all charges, whether or not covered by insurance and that I should pay any deductible or co-insurance due at time of treatment.

SIGNED:_____ **DATE:**_____

HAVE YOU HAD ANY PHYSICAL THERAPY THIS YEAR? YES____ NO_____

MEDICARE PATIENTS

ARE YOU CURRENTLY RECEIVING (IN-HOME) HEALTH SERVICES? YES ____ NO _____

***If at any time during your course of physical therapy care, you agree to or begin receiving any (in-home) health services, you will be held financially responsible for the treatment incurred from Pinnacle Physical Therapy, as Medicare does not allow you to receive both outpatient care and (in-home) care concurrently.**

_____
PATIENT SIGNATURE

*The Medicare Regulations referenced regarding Home Health Care is found on the reverse of this form

Pinnacle Physical Therapy

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Pinnacle Physical Therapy's Notice of Information Practices. I understand that Pinnacle Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided (ex. FOTO) and any administrative operations related to treatment or payment. I understand that Pinnacle Physical Therapy will consider requests for information restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Pinnacle Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, but this may lead to termination of treatment.

_____
Patient Name

_____
Signature

_____
Date

I also authorize Pinnacle Physical Therapy to accept phone calls or other correspondences regarding office appointments and billing questions from the following – please check all that apply:

( ) Spouse, children, parent and other (please specify) _____

( ) Attorney (please specify) _____

( ) Disability insurance (please specify) _____

( ) Other _____

_____
Patient Name

_____
Signature

_____
Date

Name_____ Age_____ Height_____ Weight_____

Present Occupation/Hobbies: _____

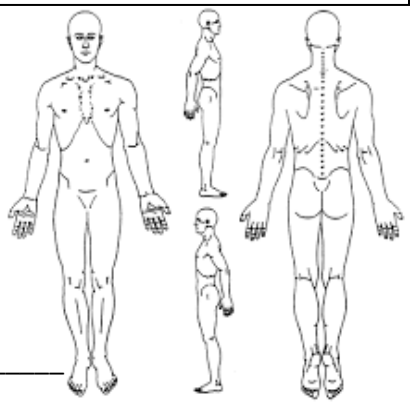
Reason for Physical Therapy/ Primary Concern? _____

Mechanism of Injury/ How did this start? : _____

How long has this been a problem? _____

Date of Surgery: (if any) _____

Mark the location of the symptoms. Prioritize with numbers if more than one location.



Is the issue changing? (circle) Better Little Better Same Worse

Rate Pain over the Last Two Weeks: 0 (no pain) – 10 (extreme pain)

With Activity 0 1 2 3 4 5 6 7 8 9 10
At Rest 0 1 2 3 4 5 6 7 8 9 10

Describe the Pain: Dull Ache Burn Sharp Stabbing None Other: _____

What Increases the Symptoms? _____

What Decreases the Symptoms? _____

Does it Wake You Up at Night? Yes No Is Sleep Normal? Yes No

Rate Your Current Level of Function (100% = normal) 0 10 20 30 40 50 60 70 80 90 100%

Please List Specific Activities that you currently have difficulty performing due to the injury: _____

_____

What is your goal for Physical Therapy? _____

Have you seen a physician regarding this condition? Yes No Next Appointment: _____

Do you understand the physician's diagnosis? Yes No Somewhat

Any Medical Tests? X-Ray MRI CT Scan Other Results: _____

Any previous or concurrent treatments for this injury? _____

Circle/Fill Out If Any Apply: Smoker: _____ Alcohol: _____ Caffeine: _____ Cancer: _____
Allergies: _____ Pregnant Change in Bowel/Bladder Function
Unexplained Weight Loss Unexplained Fatigue Dizziness/Fainting/ Shortness of Breath

Is there anything else you would like us to know? _____

I affirm this information to be true and correct to the best of my knowledge.

Signed: _____ Date: _____

Name: _____ **Date:** _____

MEDICATIONS

Name of Medication, Vitamin, Supplement	Dose (mg)	Form of Intake (Circle)	Frequency (per day)	Prescribing Physician
1		Oral/Patch/ Inhaler/Other		
Reason:				
2		Oral/Patch/ Inhaler/Other		
Reason:				
3		Oral/Patch/ Inhaler/Other		
Reason:				
4		Oral/Patch/ Inhaler/Other		
Reason:				
5		Oral/Patch/ Inhaler/Other		
Reason:				
6		Oral/Patch/ Inhaler/Other		
Reason:				
7		Oral/Patch/ Inhaler/Other		
Reason:				
8		Oral/Patch/ Inhaler/Other		
Reason:				
9		Oral/Patch/ Inhaler/Other		
Reason:				
10		Oral/Patch/ Inhaler/Other		
Reason:				