PINNACLE
PHYSICAL THERAPY

PATIENT INFORMATION

Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell phone:	Email:	
Date of Birth:	SSN:	Gender:	
Marital Status:(circle one) Single Married Divorced Widowed Other	Patient Status:(circle one) Employed Full-Time Employed Part-Time Full-Time Student		
Patient's Employer:	Occupation:	Work phone:	
Emergency Contact:	Relationship:	Emergency Phone:	
Date of Injury:	Is this a work related injury? (circle one) Yes No		
Case Manager Name:	Case Manager Phone:		
Referring Physician:	Primary Care Physician:		
How did you hear about our services? (circle one) Doctor Phonebook Sign Internet Friend (name_____)			

PATIENT INSURANCE INFORMATION

Primary Insurance Company:		
Name of Insured:	Date of Birth:	SSN:
Relationship to Insured: (circle one) Self Spouse Minor Other		
Secondary Insurance Company:		
Name of Insured:	Date of Birth:	SSN:
Relationship to Insured: (circle one) Self Spouse Minor Other		

RESPONSIBLE PARTY/GUARDIAN INFORMATION

Name First:	M.I.:	Last:	SSN:
Address:	City:	State:	Zip Code:
Relationship to Insured: (circle one) Spouse Child Other		Date of Birth:	

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Pinnacle Physical Therapy and hereby authorize and give my consent for Pinnacle Physical Therapy to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Pinnacle Physical Therapy to Treat _____(minor's name) while I am not present.

Patient/ Guardian/ Responsible Party Signature:		**Date:**

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Office Policy and Financial Responsibility

PRIVACY NOTICE and RELEASE OF MEDICAL INFORMATION: A Notice of Privacy (NPP) Practices is available for your review or you may take it with you. The NPP describes Pinnacle Physical Therapy's comprehensive efforts to protect the privacy of your personal health and financial information. The NPP also describes how such information may be used, released, or shared under the Health Insurance Portability and Accountability Act (HIPAA).

_____ **Initials**

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, **we require at least 24 hours notice of cancellation**. There is a $75 charge for cancellation without prior notice or for not showing for your appointment. The charge is not covered by insurance, and you are required to pay this fee personally.

_____ **Initials**

FINANCIAL RESPONSIBILITY: As a courtesy to you, Pinnacle Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Pinnacle Physical Therapy is not responsible for problems between the patient and insurance carrier, nor can we intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, Pinnacle Physical Therapy requires payment by the patient for any equipment/supply at the time the order is placed. We will provide documentation of the purchase so you may pursue reimbursement personally. Pinnacle Physical Therapy accepts cash, credit/debit cards, or personal checks as payment options. In the event payment is returned for insufficient funds, we will charge $30 and the amount charged by the depository will be applied to your account.

_____ **Initials**

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.
- I hereby assign payments of benefits by my insurance company to Pinnacle Physical Therapy, and I accept responsibility to ensure my insurance carrier makes payment on my account within 60 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.
- I hereby agree to pay any office visit/co-payment charges at the time of service for each visit.
- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.
-

Patient Signature: _____ **Date:** _____

Parent/Guardian/Guarantor: _____ **Date:** _____

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Pinnacle Physical Therapy
13180 James Madison Highway
Orange, VA 22960
(540) 395-3428

Name:_____ Date:___/___/___ Birthdate:___/___/____

Height:_____ Weight:_____ Referring Physician:_____

Medical History: (Please check all that apply)

_____ Heart Disease _____Diabetes_____High Blood Pressure_____Pacemaker
_____Cancer _____Tuberculosis _____Visual Impaired _____Epilepsy
_____HIV/AIDS _____Arthritis _____Hearing Impaired _____MS
_____Stroke _____Asthma _____Latex Allergy _____ Scoliosis
_____Osteoporosis _____Hepatitis _____Pregnant _____Depression _____Other: _____

Have you had positive Covid test? Y/N If so, when _____
Have you received both doses of the Covid Vaccine? _____ Date of last dose_____

Have you had surgery for your condition? Y/N Date:_____

Have you had any injections for your condition? Y/ N Date:_____

Please list any diagnostic tests you have had for this condition:_____

Please list any medications that you are taking:_____

How did the injury or problem occur? _____

When did the injury or symptom occur?_____
First episode:_____Second episode:_____Third episode:_____

What are your current symptoms?_____

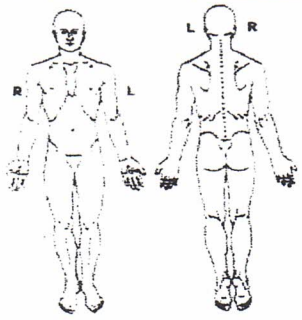
Where is your pain or problem located?_____

Is your pain Constant or Intermittent?_____
What makes your pain/problem better or worse?_____

Is there pain present at night? Y/N What position helps you to sleep?_____

Please mark on the body part by using the symbols to show type of pain.

MMM=Ache
OOO=Numbness
////= Stabbing Pain
+++=Burning
!!!!!!= Pins and Needles
?????=Other



Employment History:

Are you currently working? Y/N

How many total days of work have you missed?_____

Are your work duties Full or Restricted? How many hours per week do you work?_____

Who is your employer?_____

What type of work do you do?_____

What critical work duties have been most affected by your problem?_____

What do you hope to accomplish with therapy?_____

Medical History/Subjective Information

Please rate your pain using a 0-10 scale (0=no pain, 10=the worst pain you can imagine)

Worst pain since onset:_____ Best pain since onset: _____ Today's Pain: _____

Please rate your abilities using the following scale:

1=Can do without difficulty
2=Can do with some difficulty
3=Can do with great difficulty
4=Can't do at all

Lying down 1 2 3 4
Sitting 1 2 3 4
Standing 1 2 3 4
Walking 1 2 3 4
Jogging 1 2 3 4
Going up stars 1 2 3 4
Lifting/Carrying 1 2 3 4
Driving a car 1 2 3 4
Overhead reaching 1 2 3 4
Housework 1 2 3 4
Yardwork 1 2 3 4
Dressing 1 2 3 4
Sexual Activity 1 2 3 4

Are you exercising at home? Y/N If yes, what type?_____

Are you using heat or cold?_____

Are you wearing a sling or brace? Y/N If yes, what type?_____

Do you smoke? Y/N If yes, how much?_____

What type of non-work activities are you involved in?_____

When are you scheduled to see your doctor again?_____

To the best of my knowledge and belief, the information I have given is complete and true. I hearby give my consent to receive therapy services at Pinnacle Physical Therapy.

Patient Signature:_____