Consent for Treatment, Billing Agreement and Privacy Policies

Information for patients without insurance:

If you do not have insurance coverage, you will be expected to pay for your bill, in full at the time of service, or make appropriate payment arrangements with one of our administrative staff members. For your convenience we accept cash, checks, Care Credit, major credit cards and debit cards. Pinnacle Physical Therapy will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be Self Pay at the time of service and will not provide any documentation to Patient/Legal Guardian bill insurance, only itemization showing self pay payment.

Information for patients with insurance:

Insurance coverage is a contract between you and your insurance company. As a courtesy to you, we will file your medical claim with your insurance company in a timely manner. In most instances, we will accept payment directly from your insurance company in accordance with your policy's terms and apply the payment to your account. Contractual discounts will be applied at that time.

You are responsible for any co-payment, co-insurance, or deductible. Co-pays are expected at the time of service. Even though we provide you with the most up to date information about your benefits, ultimately, you are expected to know your co-pay and deductible amounts. **We expect payment in full on the arrival of your bill. If you are unable to pay in full we will allow 3 payments on your balance for the account to be paid in full or we do a payment plan only through Care Credit. Please ask the office staff for an application or visit www.carecredit.com.**

You will receive periodic statements indicating that we have billed your insurance company on your behalf. However, **you are ultimately responsible for payment of your physical therapy services.**
If your insurance company fails to pay your claim in a timely manner, or rejects your claim in part or in full, you are personally responsible for, and will be billed directly for the services you received. If this happens you will need to contact your insurance company directly to discuss the reason for the denial of benefits.

MISSED APPOINTMENT/NO-SHOW POLICY:

Our commitment to your well being is something everyone in our clinic takes very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need. Therefore, we expect you to keep all of your appointments. However, cancellation or the rescheduling of an appointment must be requested 24 hours notice or a $25.00 cancellation fee will be assessed. A No-Show with no attempt to contact will be assessed a $50.00 No-Show Fee

HIPPA/PRIVACY POLICY:

We are required by law to maintain the privacy of your health information and provide you with a copy of our Privacy Policy. Specifically HIPPA and Pinnacle's Privacy Policy individually identify you and relate to
(1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare. Under no circumstances is your private healthcare information given to anyone unless your consent is given. If you wish for someone to be authorized to assist you with your care at Pinnacle, written consent will be needed. We may use health information about you to provide, coordinate or manage your healthcare and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care. If you have any further questions about our HIPPA or Privacy Policy we have a copy at the front desk.

- I have read and agree to the terms of this statement.
- I consent to receive Physical Therapy care at Pinnacle Physical Therapy and Sports Medicine
- As a Guardian/Parent I consent to my dependent being seen without myself on the premises (ex: dropping off a minor to be treated)

____

Signature of Patient/Guardian Date Printed Name of Patient Date

PINNACLE PHYSICAL THERAPY

PATIENT INFORMATION:

Name____DOB ____________________
Last First MI

Sex:__Male__Female Marital Status:__Single __ Married/Partner Email:________________________________

Mailing Address _____________________ City ______________________ State_____ Zip_____________

Permanent Address (if different from current address) ____

Home Phone __________________ Cell Phone _______________ SSN _____________________________

Employer_______________________________Occupation______________________________________

Preferred method for appointment reminders __ Text __ Phone Call ___ Email

How did you hear about Pinnacle? __Physician __ Phone Book __Internet ___Friend __Other ________________

Responsible Party (if different from patient):

Name: ____ (Parent/Guardian Name)

Address: ____Phone #: _______________________

PHYSICIAN INFORMATION:

Referring Physician __________________________Primary Physician _____________________________

We would like to send the Physician who referred you a Thank You note. We want to maintain your privacy and asking if this would be acceptable. Do you agree that we can do this? YES ___ NO ___

ACCIDENT INFORMATION: Type: Work Auto Sport Other

Date of Injury: ____________ Claim #:___________________ Place of Injury: ______________________

Brief Description of Injury: ____

____

INSURANCE INFORMATION: (If you have your insurance card we can copy and you do not need to fill this part out)

Primary Ins. _______________________________Subscriber Name:_____________________________
Date of Birth: ____________ Policy #: ____________________________Group #: __________________
Secondary Ins. ______________________________Subscriber Name:_____________________________
Date of Birth: ____________ Policy #: ____________________________Group #: __________________

Medicare Patients:

Have you had physical therapy this year? ___ Y ___N
Have you had Home Health Care this year? ___ Y ____N

MEDICAL PROFILE QUESTIONNAIRE

Name_______________________________________ **Age** _________ **Date**_________

Height **Weight** **Date of Injury and/or Surgery**_________________________

What are your main complaints or concerns (what brought you to therapy)?

____

____

What is your main goal or objective in coming to therapy?

____

____

If any, what other treatment has been tried for this problem (medications, chiropractic, ice…)**?**

____

MEDICARE PATIENTS: Have you fallen within the last year? Yes No

If yes, how many times? _____ **Were you injured in the fall(s)?** ______________________________

Past Medical History: Please mark any you *have* or *have had*

	Cancer(s):		Diabetes
	Surgeries:		Head Injury
	Heart problems:		Seizures
	Do you have a pacemaker? Yes No		Stroke
	Arthritis:		Lung Problems
	Tape or latex allergies Yes No Any other allergies?		High Blood Pressure
	Vascular problems:		Depression
	Hospitalizations:		Thyroid Problems
	Other:		Kidney Problems

Medications* (Prescription and Over the Counter) or supplements you are currently taking

Name	Dosage	Frequency (circle one):	Form (circle one):
		_____ times a day / week	Oral Injection Other:
		_____ times a day / week	Oral Injection Other:
		_____ times a day / week	Oral Injection Other:
		_____ times a day / week	Oral Injection Other:

*If medication outnumbers four, please attach a separate list or use the back of this page.

PINNACLE
PHYSICAL THERAPY

Patient's Name: ______________________ **Date:** _____________

On a scale from ZERO (0) as NO PAIN, and TEN (10) as THE WORST PAIN, rate:

The best it has been _______/10. The worst it has been _______/10. Pain in the past week _______ /10.

Pain at rest _________ /10. Pain with activity __________/10. Pain now __________ /10.

When did your symptoms begin? (as close to the actual date as possible) ________________________________

How would you rate your overall health (circle one): Excellent Good Fair Poor Very Poor

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Shade the location of pain in the body diagram and circle your pain descriptions below:

Aching *Dull*

Stabbing *Radiating*

Shooting *Catching*

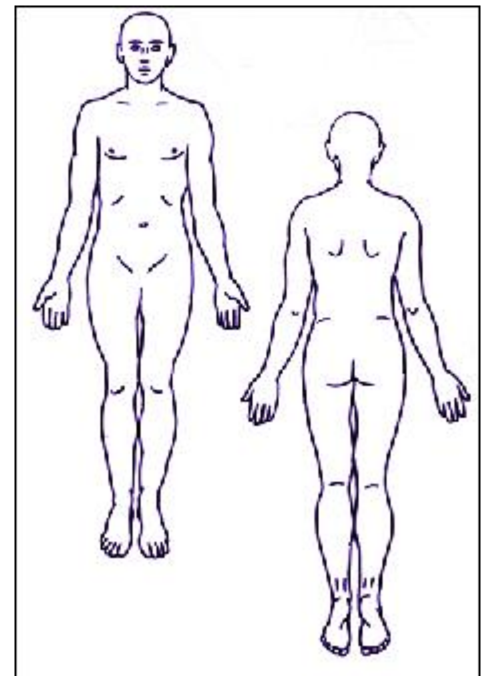
Throbbing *Burning*

Numbness *Tingling*

Pins & Needles *Sharp*

Pain Key:

== Numbness
XX Burning
++ Aching
/// Shooting
Pins/Needles



Have you had this problem before? YES / NO If YES, did you receive treatment and was it helpful?

____

Before the present pain / injury, what types of exercise / activities were you doing, how frequent?

____