PINNACLE
PHYSICAL THERAPY
SPINE & SPORT

WELCOME SHEET

PATIENT INFORMATION

Full Name: _____ Today's Date: _____

Home Address: _____ Age: _____ Gender: M F

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Home Phone: _____

Birth Date: ____ / ____ / _____ Social Security #: _____ - _____ - _____ Spouse's Name: _____

Occupation: _____ Employer Name: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Home Phone: _____ Emergency Contact Work Phone: _____

Primary Care Doctor: _____ Doctor Phone: _____

Is your preference to receive appointment reminders by: ( ) Phone: _____ ( ) Text: _____

* How did you hear about our clinic?
( ) Doctor ( ) Patient ( ) Yellow pages ( ) Drive By ( ) Internet: _____ ( ) Other: _____

* Whom may we thank for referring you? _____ Have you visited our website? Y N

* If you have visited our website, did you use it to: ( ) Find a PT ( ) Research Pinnacle PT ( ) Get Directions ( ) Other: _____

INSURANCE INFORMATION

Name of insurance company: _____ ID #: _____

Claim or Group #: _____ Insured's Name if different than yours: _____

Relationship to Insured: _____ Birth Date: ____ / ____ / _____ Employer: _____

SECONDARY INSURANCE INFORMATION (Any coverage in addition to primary)

Name of insurance company: _____ ID #: _____

Claim or Group #: _____ Insured's Name if different than yours: _____

Relationship to Insured: _____ Birth Date: ____ / ____ / _____ Employer: _____

ACCIDENT INFORMATION

Is this condition due to an accident? Y N Date of accident: ____/____/____

Name of At Fault Insurance Company: _____

Type of accident: ( ) Auto ( ) Work ( ) Home ( ) Other Do you have an attorney? Y N

Attorney Name: _____ Attorney Phone: _____

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Pinnacle Physical Therapy all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Pinnacle Physical Therapy may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ **Date:** _____

4025 Cherry Avenue NE ▪ Keizer, OR 97303 ▪ 503-390-9009 ▪ Fax 503-393-0834
210 W Ellendale Avenue Suite 100 ▪ Dallas, OR 97338 ▪ 503-623-2433 ▪ Fax 503-623-2196

PINNACLE
PHYSICAL THERAPY

FINANCIAL POLICY

Our fees are comparable to the usual and customary charges of other physical therapists in our area. These customary charges are based upon cost, time, and skill involved. Patients without insurance coverage are requested to pay their charges at the time service is provided. Patients with insurance coverage are responsible for co-pays at the time of every visit.

Invoices will be sent once a month at the beginning of each month on accounts with charges not covered by insurance. Invoiced accounts that remain unpaid by the 15th of the month will be subject to a $5 late charge. Accounts with returned checks will be charged a $40 returned check fee. Payment plans are available.

OUR POLICY ON INSURANCE

Please remember that insurance estimates are based on information provided by your insurance company. The amount of insurance coverage estimated is an estimate only, and may not reflect what your insurance carrier will *actually* pay under your policy.

We will gladly discuss your treatment with you and answer any questions relating to your insurance to the best of our ability. However, you must realize that:

- Your insurance is a contract between you and your insurance carrier, and may involve your employer. We are not a party of that contract.
- Not every service we provide may be a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
- Services may be provided on the assumption that the charges will be paid by the insurance company; however, the patient understands that they are ultimately responsible for treatment costs, not covered by insurance.

As a courtesy, advance notice for missed appointments is required. There will be a $40.00 fee in the event you miss an appointment without giving a 24-hour notice. You will be *personally* responsible for this fee - it will NOT be billed to insurance. Patients who are late to appointments by 10 minutes or longer will forfeit their reserved appointment time and a $40.00 fee will be applied. Missed appointments that have been rescheduled due to avoiding cancellation charges will be subject to a $40.00 fee. Pinnacle Physical Therapy reserves the right to discharge patients for the reasons of non-compliance of therapy appointment times at the discretion of the clinic manager.

Initials _____

If you have paid on your account, and an insurance payment results in a credit balance, a refund will promptly be sent to you.

PATIENT AGREEMENT:

I have read and fully understand this document, and I am voluntarily signing this document. I hereby assign the insurance benefits that are otherwise payable under my insurance policy to Pinnacle Physical Therapy for services provided, and direct that insurance payments be made directly to them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not I have insurance. I further authorize Pinnacle Physical Therapy to release all information necessary to secure payment.

_____	_____	_____
Patient or Guardian Signature	Patient or Guardian Printed Name	Date

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Informed Consent

The physical therapists at Pinnacle Physical Therapy, P.C. wish to inform you of the treatment you will be offered, the potential risks involved, and the alternative treatment options you may consider.

We take your safety and health very seriously. The physical therapists at Pinnacle Physical Therapy, P.C. are highly trained and extensively educated to provide safe and effective care. Every precaution will be taken to assure your comfort and health. Every patient's treatment is unique, and your personalized treatment may include some or all of the following treatments and procedures:

- mobilization of the spine or extremities
- heat pack application
- massage therapy
- spinal traction
- ultrasound
- electrical modalities
- exercise rehabilitation
- paraffin bath
- orthotic fitting
- MSKUS
- NCS / EMG
- _____

Physical therapy is a medical procedure. All medical procedures involve some potential risks, although minimal and very rare in physical therapy. Complications are extremely uncommon; however risks may include dizziness, pain, skin discoloration, fracture, dislocation, stroke, burn, electrical shock, swelling, or headache.

Alternatives to physical therapy include home or gym exercise and stretching, weight control, medicines, and care from other medical providers. *(None of these options are without risk either)*

PLEASE CONSULT WITH THE PHYSICAL THERAPIST OR YOUR DOCTOR PRIOR TO YOUR TREATMENT IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR PERSONALIZED TREATMENT. _____

_____

_____

(PRINT NAME)

I, _____, ACCEPT TREATMENT, and have been informed of the risks, have been notified of alternative care options, and have opportunities to discuss any questions I had prior to consenting to care.

_____ _____
Patient Signature Date

_____ _____
Physical Therapist Signature Date

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PATIENT QUESTIONNAIRE

Name:_____ Date_____
Date of Birth:_____
Occupation:_____
Diagnosis:_____
Date of Injury or onset:_____
Date of surgery:_____
Referring Physician:_____

What are your symptoms? _____
_____
_____

How did your injury occur or your symptoms begin?_____
_____
_____

Pain level: 0= no pain, 10= excruciating pain (please circle the appropriate number)
Today's pain: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Nature of symptoms (circle all that apply) Sharp Dull Throbbing Aching Periodic Constant Intermittent Other_____

What aggravates your symptoms?(Circle all that apply) Lying Sitting/Rising Standing Walking Bending/Stooping In/Out of car Other_____

What relieves your symptoms? Lying Sitting Standing Walking Resting Medication Exercise Nothing Massage Heat Ice Wearing a splint/orthotics

Does this injury/pain awaken you at night? Yes No If pain awakens you, can you get back to sleep? Yes No
Position(s) of comfort_____

If you have back/neck pain, does coughing worsen your symptoms? Yes No If you have back/neck pain, do symptoms radiate down into arms or legs? Yes No If yes, which side? Right Left Both

Have you experienced any unexpected weight loss recently? Yes No

Any recent X-rays, MRI, or diagnostic ultrasound tests? Yes No

List medications for current problem.
_____
List other medications you are currently taking._____
_____

Past medical History (please list accidents, falls, surgeries, current or chronic illnesses)_____
_____

Please place a mark on the line below indication your current activity level (i.e. are you able to participate and do the activities you want to with your current injury)
No activities _____ _____normal activities
Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain .
(///) Stabbing (xxx)Burning (+++) Aching (000) Pins & Needles (= = =) Numbness