

Patient Information

Last Name/Suffix		First Name		Middle Initial
Address:		City	State:	Zip Code:
Home Phone		Other Phone (Cell)		Email Address:
Date of Birth	SSN	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	

Employer Information

Employer Name:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Work Phone Number		Patient Occupation		

Primary Insurance Carrier / Policy Holder Information

Primary Insurance:		Insurance Identification Number:		
Policy Holder Name:	Is policy holder a RETIRED Federal Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:		
Policy Holder Home Phone:		Employer / Employer Address:		

Secondary Insurance Carrier / Policy Holder Information

Secondary Insurance:		Insurance Identification Number:		
Policy Holder Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Policy Holder Date of Birth:	Policy Holder SSN	Policy Holder Address:		
Policy Holder Home Phone:		Employer / Employer Address:		

Physician Information

Name of Referring Physician:	Name of Primary Care Physician:
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Emergency Contact Information

Contact Name:	Phone #:	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other
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Additional Questions

Date of Injury / Onset Date	Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Auto-State? _____ <input type="checkbox"/> PI	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis/Body Part
Post Surgical: <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown Surgery Date (if applicable): _____		Surgery Description: _____	
Have you had any prior Therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No (PT/OT/SP or Chiropractic)		How did you hear about us?	

I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner

Appointment Date:	Time:	Therapist:
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Intake Completed By:	I, acknowledge that the above information is correct	
_____	Patient/Guardian	Date:
Date: _____		

Pinnacle PT

CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for Pinnacle PT/Pinnacle Rehabilitation Network, L.L.C to furnish medical care and treatment to, _____, considered necessary and proper in diagnosing or treating his/her physical condition.

_____ Patient/Guardian Initials

PRIVACY NOTICE

A copy of our Privacy Notice, which describes how your medical/account information may be used and disclosed, has been given to you to review. Should you want a copy, please ask the receptionist.

PLEASE REVIEW IT CAREFULLY and let us know if there are any exceptions.

_____ Patient/Guardian Initials

FINANCIAL POLICY STATEMENT

- We do our best to verify your insurance information as a courtesy to you. However, it is not a guarantee of payment. Co-pays will be collected at the time services are rendered. If you have co-insurance or a deductible, a bill will be sent to you for prompt payment. **Due to the fact that benefits are determined at the time the claim is processed, when payment from your insurance company is received, we will know then if it is necessary to modify your co-pay amount; or the amount to bill you for your co-insurance or deductible.**
- Be advised if you claim worker's compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Pinnacle PT/ Pinnacle Rehabilitation Network, L.L.C.
- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee within 30 days of the returned check.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs and attorney fees.
- **I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.**

_____ Patient/Guardian Initials

BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payors to Pinnacle PT /Pinnacle Rehabilitation Network L.L.C

Patient/Guardian _____ Date _____