PATIENT INFORMATION

Name (Last, First, M.): ____ Gender: ☐ Male ☐ Female

Address: ______________________________________ City: ________________ State: ____ Zip: ________

Home Phone: (____) _____-______ Work Phone: (____) _____-______ Cell Phone: (____) _____-______

E-mail: ____________________________ Method for appointment reminders: ☐ Phone ☐ Text ☐ Email ☐ None

Employer: _______________________________ DOB: ____/____/______ Soc. Sec. Number: ______-____-______

How did you hear about us? ☐ Drive by/saw sign ☐ I'm a previous patient ☐ Flyer ☐ Newspaper
☐ Family/friend/patient ☐ Referred by doctor. Name: ____________________
☐ Email ☐ Insurance ☐ Internet: _____________ ☐ Other: _____________

RESPONSIBLE PARTY INFORMATION (Please fill out if different than patient information above)

Name of responsible party: ___________________________ DOB: ____/____/_____

Address: ____ Soc. Sec. Number: _____-_____-______

Insurance Type: ☐ Private Insurance ☐ L&I ☐ Auto

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Phone: (____) _____-______ Relationship: ________________

PROXY AUTHORIZATION (Release of information to others)

I hereby authorize Pinnacle Medical Wellness, through its appropriate personnel, to communicate with ________________________, my (Circle one) husband/wife/mother/father/son/daughter/significant other/friend regarding my appointments, medical records and billing for services rendered on my behalf. I grant Pinnacle Medical Wellness to leave a message regarding my upcoming appointments, treatment related issues, and account information at the following numbers:

At my home number: (____) _____-______ with (name): ____

At another number: (____) _____-______ with (name): ____

INFORMATION CONSENT AND FINANCIAL RESPONSIBILITY

I hereby authorize Pinnacle Medical Wellness to render treatment, furnish information, and medical records to my physician, insurance carriers, appeal claims denied by my insurance company on my behalf, attorney or employer concerning myself or my dependents illness and treatment. I hereby assign to the provider all payment for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance and I will not withhold or delay payment if my insurances denies payment. If you are receiving home health services and have not been discharged from their care, Medicare will not pay and the patient will be responsible for the balance. I agree to comply with the terms and conditions as outlined in the financial policy form. I acknowledge that I have been offered a copy of the Pinnacle Medical Wellness Privacy Practices.

______________________________ ____________________________________ ____________________

Patient's Signature Parent/Legal Guardian's Signature Date

Acknowledgement of Receipt of Privacy Practices (HIPAA)

I have read and fully understand Pinnacle Medical Wellness' Notice of Privacy Practices. I understand that Pinnacle Medical Wellness may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Pinnacle Medical Wellness will consider requests for 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 Medical Wellness' Notice of Privacy Practices.

Responsible Party Initials ________

Insurance and Financial Policy

I hereby assign all medical benefits to which I am entitled to Pinnacle Medical Wellness in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. **I understand that Pinnacle Medical Wellness strongly encourages me to check my benefits with my insurance company.** Should I decide not to check my benefits, I understand that any fees accrued that the insurance company does not pay will be my responsibility. All balances are due within 30 days. A $25.00 fee will be charged to me for each incident that a check is returned to Pinnacle Medical Wellness with insufficient funds. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, all court costs, and balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said medical practices by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence. AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

Responsible Party Initials ________

Worker's Compensation Claims

Pinnacle Medical Wellness will bill your **open**, approved worker's compensation claim. Please be advised that in the event your claim is denied you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated with Pinnacle, you are responsible for keeping track of your authorized visits. In the event you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible for any denied visits.

Responsible Party Initials ________

Scheduling & 24-Hour Notice

We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice. If you continually fail to attend your scheduled appointments and do not give us prior notification, you will be assessed a fee of **$40.00.** If you fail to show for two consecutive sessions, we will consider you discharged from our care at that time. If you are a L&I patient, your claims manager will be notified about the missed visits, and you will be discharged from care. A new referral from your referring physician will be required to reschedule any future appointments.

Responsible Party Initials ________

Non-Discrimination

Admission to our clinic is non-discriminatory for services rendered regardless of race, color, national origin, disability or age. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 protect all clients who come to our clinic for Services.

Responsible Party Initials ________

______________________	______________________	______________________
Patient's Name	Patient/Responsible Party's Signature	Date

Verifying Your Insurance Benefits

It's important that you are aware and understand what your benefit coverage is for your health insurance. If you plan to seek reimbursement from your insurance company for any of the services offered at Pinnacle, we encourage you to check your benefits. To aid you in doing this, we have provided you with a template from which to work. Please understand that when you are discussing your benefit coverage with your insurance company any quotes that they may provide you is **not a guarantee of payment**, and any fees accrued that the insurance company does not pay will be your responsibility. (Please note if you will also be seeking reimbursement from a secondary insurance plan you will need to check those benefits separately.)

Should you decide **not** to check your health insurance coverage, that is your right, but understand that **any** fees accrued that the insurance company does not pay will be your responsibility. Please read and sign the following statement.

I understand that verifying my health insurance benefits is voluntary, but **strongly encouraged**. I also understand that I am financially responsible for all charges should my insurance company deny any portion of my claim(s) for any reason. In the event my account becomes delinquent and is therefore in default of payment, I understand that as the account responsible, legal guardian, or admitting parent, I am responsible for the principle amount owing and all reasonable costs associated with the collection of this debt, including but not limited to, collection services fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt.

______________________________	____________________________________	________________
Patient's Name	Patient/Legal Guardian's Signature	Date

PINNACLE
MEDICAL WELLNESS
PHYSICAL THERAPY NUTRITION FITNESS MASSAGE

Verifying Your Health Insurance Benefits Worksheet

Please take this worksheet home to check your benefit coverage with your insurance company for all of the services Pinnacle Medical Wellness offers. You will need to have your insurance card prior to calling your insurance provider's customer service number. This number is located on the back of your insurance card. If you are not the primary card holder, you will need to know the primary card holder's date of birth and possibly his/her social security number. Pinnacle's NPI number is 1225116916 should your carrier require it.

General Information

What is my deductible? ________ How much have I met? ________

Do I have a co-pay? Yes No If yes, how much is it?

Do I have co-insurance? Yes No If yes, how much is it?

Physical Therapy & Occupational Therapy – (please state that you are inquiring about **outpatient** benefits)

What is Physical Therapy/Occupational Therapy covered at? _______ How many visits do I get? _______

Are these visits combined with any other services? Yes No If yes, which ones? ________

Do I need a prescription or referral from my doctor? Yes No

Do I need to get pre-authorization before I start? Yes No

Massage Therapy – Note a prescription from your doctor is strongly recommended, even if not required.

Is Massage Therapy by a **Licensed Massage Therapist** covered?* Yes No How many visits do I get? _______

Are these visits combined with any other services? Yes No If yes, which ones? _______

Do I need a prescription or referral from my doctor? Yes No

Do I need to get pre-authorization before I start? Yes No

***NOTE:** If your insurance company says that you have massage benefits if performed by a physician, chiropractor, or physical therapist, your benefits will NOT cover the medical massage therapy offered at Pinnacle or any of the other providers in the area.

Medical Nutrition Therapy

Is Nutrition Counseling by a **Registered Dietitian and/or Certified Nutritionist** covered? Yes No
How many visits do I get? ________

Are these visits combined with any other services? Yes No If yes, which ones? ________

Do I need a prescription or referral from my doctor? Yes No

Do I need to get pre-authorization before I start? Yes No

Is metabolic testing covered? Yes No

Orthotics

Are custom molded orthotics covered? Yes No How many do I get? _______

Do I need a prescription or referral from my doctor? Yes No

PINNACLE MEDICAL WELLNESS

PHYSICAL THERAPY NUTRITION FITNESS MASSAGE

Name:__________________________ DOB: ____________ Age: ______ Occupation: _______________________

Please check any of the following health conditions that you currently or previously experienced.

Musculoskeletal

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Dislocations
- ☐ Fractures/Broken Bones
- ☐ Disc Herniation/Rupture
- ☐ Swelling
- ☐ Headaches

Change In Health

- ☐ Decreased Coordination
- ☐ Fever/Chills/Night Sweats
- ☐ Numbness/Tingling
- ☐ Nausea/Vomiting
- ☐ Appetite Changes
- ☐ Unexplained Weight Loss
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Vision Changes
- ☐ Bowel/Bladder Changes
- ☐ Other: ____________________

Medical History

- ☐ Cancer
- ☐ Diabetes If yes: ☐ Type I ☐ Type II
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ History of Falling
- ☐ Stroke or ☐ TIA (small strokes)
- ☐ Seizures
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Gastrointestinal
- ☐ Angina/Chest Pain
- ☐ Pacemaker
- ☐ Thyroid Problems
- ☐ Communicable Disease (i.e. HIV, Hep C)
  If Yes, _____________
- ☐ Under Stress
- ☐ Depressed
- ☐ Currently Pregnant
  If Yes, due date: ____________

List current medications (including blood thinners):

____

____

____

____

List any previous injuries/surgeries in the past 3 years (i.e. fractures, dislocations, or surgeries):

____

____

____

____

How often do you exercise?
Daily, ___ Times/Week, Rarely

What type of exercise(s)?

____

Do you smoke? ☐ Yes ☐ No
If so, how much? _____________

Would you like information on smoking cessation? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No
If so, how much? __________________

What was the date of the injury? ________________________

What would you like to achieve by attending therapy? ____________________

____

Please rate your pain level: (no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst)

What makes your pain worse? ______________________________________

What makes your pain better? ______________________________________

What treatments have you had for this injury? ☐ Chiropractor ☐ Massage ☐ Acupuncture ☐ Other: _____________________________

Did they help? ☐ Yes ☐ No

Presently are you getting: ☐ Better ☐ Worse ☐ Same

Have you had a similar injury before? ☐ Yes ☐ No

If yes, then when? _________________

Is there anything else we should know about your medical history?

____

Mark the part of the body we are treating: