PINNACLE
PHYSICAL THERAPY
& PILATES OF BOULDER

Patient Intake Form

First and Last Name:

Birthdate (mm/dd/yyyy): Occupation:

Home Street Address:

City, State, Zip Code:

Email Address:

Daytime Phone Number: Eve:

How did you hear about Pinnacle Physical Therapy?

- My doctor referred me
- A friend referred me
- Web search
- I chose from a list provided by my doctor
- I chose from a list provided by my insurance company
- Other

Emergency Contact's Name: Phone Number:

Financial Responsibility (if different than the client/patient)

Name of Policyholder:

Relationship to Patient/Client:

Birthdate of Policyholder (mm/dd/yyyy):

Name of your Health Insurance Company:

Address:

MEDICARE PATIENTS

If you are a Medicare patient, you must have a doctor to whom we can send a Plan of Care for their signature, or Medicare may deny payment.

Name of doctor:

ALL PATIENTS

Date of next visit with your doctor (mm/dd/yyyy):

Notice of Privacy Practices (HIPAA)

This notice can be read on the website at www.pinnaclephysicaltherapyboulder.com. You also will be provided a copy of this notice to read at your first appointment.

Please sign your name indicating that you have been provided with this information.

Handwritten Signature: _____ Date:_____

Electronic Signature: Date:

Electronic Signature of Patient Representative:

Office Policies

We are dedicated to providing highly individualized care for patients with orthopedic conditions. Your plan of care is achieved through the professional assessment of your therapist and possibly your physician, and is based on your specific functional goals. Please read the following policies and sign below.

Authorization for Treatment/Photography

I consent and authorize Pinnacle Physical Therapy (PPT), P.C. to provide physical therapy as ordered by my physician or per the findings of the physical examination by the Physical Therapist. Treatments may include, but are not limited to, therapeutic tests, treatments or procedures, mobilization or stretching and exercise treatments. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs and/or videos relating to my physical condition and treatment as are deemed necessary by PPT.

Release of Information

This authorization, or copy of the same, authorizes Pinnacle Physical Therapy to release any medical information necessary for treatment and/or process claims for service rendered by the Provider.

This authorizes PPT to disclose any information obtained by your provider, in connection with the patient's treatment (including information concerning a related Medicare claim) to any physician, governmental agency (including the SSA or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

Patient and authorized Patient Representative agrees to execute any documents and perform any acts that PPT may reasonably request, with regards to therapy service.

Patient and authorized Patient Representative acknowledges receipt of PPT's Notice of Privacy Practices.

The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, healthcare surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.

Reimbursement Coverage/Financial Agreements for Medicare Recipients

Patient or authorized Patient Representative hereby assigns to PPT all private medical insurance benefits (primary and secondary, including Medigap providers) or other benefits to which Patient may be entitled for any therapy service rendered by the Provider.

Patient or authorized Patient Representative authorizes and directs PPT to apply and files for all such benefits on behalf of Patient.

Patient or authorized Patient Representative agrees that he/she shall be jointly and severally responsible for any financial portion of Provider's invoice that is not paid, including but not limited to (i) any applicable deductibles or co-insurance, (ii) any non-insured or non-covered services authorized, or (iii) any charges in excess of payment limitation imposed by third party payers, except in the event of Medicare denial.

Patient or authorized Patient Representative authorizes PPT to represent Patient during the appeals process in the event of a denial of Medicare benefits.

Should your account be referred to any attorney or collection agency, the Patient or the Patient Representative understands that he/she will be responsible for attorney and or collection expenses.

Reimbursement Coverage/Financial Agreements for Commercial Insurances

Insurance policies have different plans covering PT services. We will assist you in any way we can, but ultimately it is your responsibility to understand your coverage. To obtain information about your specific plan we encourage you to contact your insurance company's customer service department. The number is on the back of your insurance card.

For Anthem BC/BS, Aetna there are market forces in play that drive reimbursement to your providers to be lower than the cost of providing the service. We can no longer afford to pay personnel to directly deal with the previously mentioned insurances and accept assignment. Therefore, we will ask you to pay in full for your service each time you are seen. We will bill your insurance directly, and if you are to be reimbursed at any level, you will receive the payment directly.

Term

This patient consent and authorization given to PPT as set forth above will remain in full force and be effective until said consent is terminated in writing by patient or authorized patient representative.

Cancellation/No Show Policy

Cash Pay, Private Insurance and Medicare Patients:

Any no-shows or cancellations that are not made 24 hours in advance of your scheduled appointment time are subject to a $70.00 fee, which will be billed to your personal account.

Durable Medical Equipment

DEM and supplies are not reimbursed by insurance companies and must be paid for at the time of service.

Payments

Co-payments are to be paid at the time of service. We accept cash, checks, Visa, MC and will consider a payment plan if needed.

***Courtesy Option**—we can securely keep you credit card information on file and will bill any unpaid balance to the card after 30 days of invoicing. Once your bill is paid in full, your information is deleted.

Late Charges/Returned Checks

Any account that remains open beyond 30-60 days from the last date of service will be subject to a $10.00 fee for each month that the account is not paid in full.

Fees

As our fees are subject to change without notice, please see our latest fee schedule online. After the initial evaluation, subsequent PT sessions are billed in 15 minute increments and are typically one hour in duration. The therapist reserves the right to treat the patient for a 50-minute treatment session, leaving 10 minutes for the necessary paperwork and documentation required by law.

Signature of Acceptance for Above Office Policies

I have read the above policies and understand each aspect of PPT's Office Policies. I agree to accept full financial responsibility for services rendered at PPT.

Handwritten Signature: _____ Date: _____

Electronic Signature: Date:

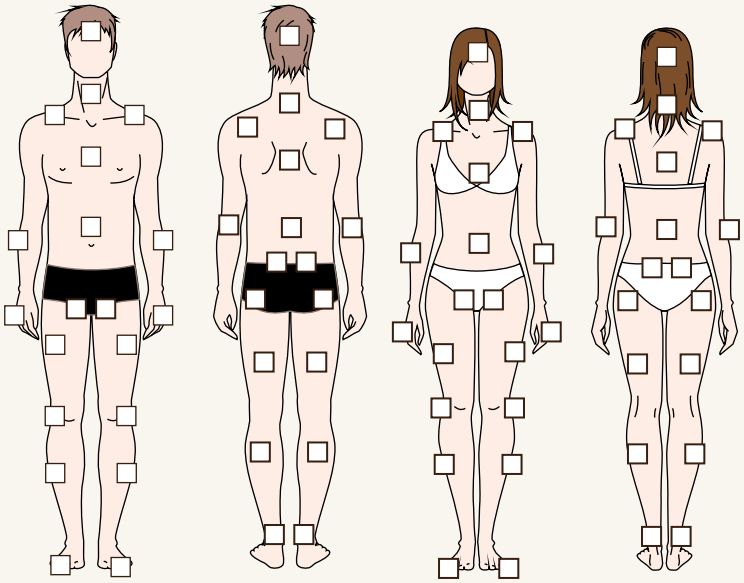
Electronic Signature of Patient Representative:

Primary Goals For Your Physical Therapy Visit

Briefly describe your injury, surgery or site of pain and how it has affected your physical health. This is a good place to record the dates of when things occurred. You will have the opportunity to discuss this more in depth with your Physical Therapist.

Mark on the body chart where you have **ANY** discomfort or pain, whether it is related to this condition or not.

Description of discomfort/pain:



List your goals for physical therapy:

1.

2.

3.

Describe your regular physical activity:

Describe the activities you enjoyed when you were between 12 and 20 years old:

Functional Outcomes

Describe how your pain/injury/surgery affects your day-to-day activities. If your pain/injury/surgery does **NOT** affect your daily activities, check the NA column.

Pain level (0–10): 0 = no pain, 10 = hospitalization

Difficulty level (0–5): 0 = no difficulty performing task, 5 = impossible to perform task

Confidence level (0–5): 0 = fully confident in performing task, 5 = no confidence in performing task

	N/A	Pain level											Difficulty						Confidence					
		0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	0	1	2	3	4	5
Sleeping	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Sitting, driving	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Standing	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Walking	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
General exercise	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Light activity (cooking, dressing, bathing)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Up/downstairs	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bending/stooping	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Reaching	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kneel/squat	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Lift/carry	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Grasp/push/pull	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Getting up from chair or bed	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Getting up from floor	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Balance	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

List the three activities above that are most important for you to regain as soon as possible:

1.

2.

3.

Problem area(s)	What makes your condition feel better?
Example: left shoulder	*Ice, ibuprofen, rest, massage, heat, ice, wraps…*

My General Health

Complete the following statement by ticking one of the choices 1–5.

In general, my overall health is…

○ 1. Poor ○ 2. Fair ○ 3. Good ○ 4. Very good ○ 5. Excellent

General health indicators	Numbers (if you known them)	Date of most current test	Medication used to manage this condition
Blood pressure			
Cholesterol			
Triglycerides			
Glucose			
A1C			
Thyroid			
Height/weight (BMI)			
Waist circumference			
Fatigue—loss of energy			
Anemia			
Number of falls in last 5 years			

What is the name of your Primary Care/GP/Family Doctor?

List any meditations taken	List any vitamins/supplements taken

Do you smoke? ◯ Yes ◯ No

Did you ever smoke, and if so, when did you quit?

List all surgical interventions	Approximate date	Additional information
Example: appendectomy	*1988*	*Complications with infection*

List all injections (spinal or joint) you have received in the last 10 years	Approximate date(s)	Additional information
Example: Synvisc, right knee	*2012, 2013*	*Helped a lot*

Your personal medical history	Approximate date(s)	Additional information
Broken bones		
Sprains/strains		
Asthma or lung disease		
Bowel polyps or IBS		
Chronic bronchitis, COPD		
CAD, CHF, angina, stings, or heart attack		
Depression		
Cancer		
Stroke/blood clot		
Visual impairment		
Hearing impairment		
Hepatitis		
HIV		
Osteoarthritis/osteopenia		
Rheumatoid arthritis/lupus		
Foot orthotics		
Mouth appliances		
Incontinence of bowel or bladder		

List of any diagnostic tests you've had	Approximate date(s)
Example: MRI on left knee	*May 2013*

Have you received any of the following services this calendar year?

☐ Physical Therapy ☐ Speech Therapy ☐ Home Health ☐ Hospice

My Readiness

To create lasting physical change that results in pain relief or return to previous levels of function, it is important to recognize how willing you are to make changes in your current lifestyle and to discover any barriers you see that may limit your ability to change.

Check the box indicating the sentence that best applies to you right now:

☐ I am already doing many things to help myself

☐ I just started recently to address this condition

☐ I am planning to address this condition with today's visit

☐ I won't address this condition

☐ I can't address this condition

Importance of addressing this condition. Select the box by the number that best applies:

Not important **Most important**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If you did not have this condition, paint a picture of what that would look like, or what you might be doing, or how you might be feeling:

My Confidence

Select the number that best applies to how confident you are right now that you are ready to address this condition.

Not confident **Very confident**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If your answer is below 7, explain what it would take to raise your answer to higher than 7.

What strengths or values do you have that have allowed you to be successful in the past, perhaps dealing with an injury or surgery? These might be things like, "I have great support at home," or "I have a can-do attitude," etc… Your physical therapist will use your strengths and values to help you achieve your goals.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM