PINNACLE SURGICAL ORTHOPEDICS | Advanced HEALTH

Questionnaire

Patient Health

Patient Name: **OB:** **Patient ID:**

Current **employment status**? ❑Occupation_____ ❑Retired ❑Student ❑Disabled

Work activities mostly include: ❑Sitting ❑Standing ❑Walking ❑Lifting ❑Bending ❑Computer ❑Driving ❑Varied

❑Other:_____

How do you **rate your health**? ❑Excellent ❑Good ❑Fair ❑Poor

When did your **current symptoms begin**? (*date*)____/____/____or (*time period*) _____

Have you experienced these **symptoms before** (please explain)?

Do you currently **exercise, play sports** or **have hobbies** (*if yes, please describe*)?

How did your **injury occur** or **symptoms begin** (*check all that apply*)?

❑ Accident – Work Related	❑ Bending	❑ Reaching	❑ Other:
❑ Accident – Motor Vehicle	❑ Falling	❑ No Apparent Reason	
❑ Accident – Liability / 3rd Party	❑ Lifting	❑ Gradual Onset	

Indicate daily **activities you are having trouble with** due to this injury or onset of symptoms (*check all that apply*)?

❑ Sitting minutes	❑ Standing____minutes	❑ Reaching	❑ Dressing
❑ Rising	❑ Turning	❑ Lying	❑ Housework
❑ Bending	❑ Walking____feet	❑ Sleeping____hours	❑ Athletics
❑ Driving	❑ Stairs	❑ Grooming	❑ Other:

What **treatment & testing** have you received (*check all that apply*)?

❑ Physical Therapy	❑ Bracing	❑ Nerve Conduction Study
❑ Occupational Therapy	❑ Orthotics	❑ Myelogram
❑ Chiropractic	❑ X-Ray	❑ Other:
❑ Injection	❑ MRI	
❑ Medication	❑ CT Scan	

If you had **surgery**, list the **type of surgery**_____ and **date of surgery**____/____/____

Do you currently have any **"flu type"** symptoms (i.e. fever, coughing)?

❑ Yes ❑ No If yes, what symptoms:

Do you have any **open cuts, lesions or wounds**?

❑ Yes ❑ No If yes, where:

Have you **fallen** in the past year?

❑ Yes ❑ No If yes, how many times:

If yes to falling, did you **sustain an injury** as a result of the fall?

❑ Yes ❑ No

Do you experience **frequent episodes** of the following (*check all that apply*)?

❑ Headaches ❑ Dizziness ❑ Nausea ❑ Ear Ringing ❑ Balance Control

Have you noticed a change in your **bowel or bladder frequency or control**?

❑ Yes ❑ No If yes, please explain:

Do you wear glasses or contacts?

❑ Yes ❑ No

Patient Name:	DOB:	Patient ID:

Do you have, or have you had, **any of the following** (*check all that apply*)?

	Yes	No		Yes	No	
Asthma	❑	❑	Metal Implants	❑	❑	List additional history:
Cancer	❑	❑	Osteoarthritis	❑	❑	
COPD	❑	❑	Osteoporosis	❑	❑	
Currently Pregnant	❑	❑	Pacemaker	❑	❑	
Diabetes	❑	❑	Peripheral Vascular Disease	❑	❑	
Epilepsy	❑	❑	Previous Surgery	❑	❑	
Heart Condition	❑	❑	Rheumatoid Arthritis	❑	❑	
Hypertension	❑	❑	Stroke History	❑	❑	

Use the following scales to **rate your average symptom level** (*circle the appropriate level for each body part*).
"0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10 **Arm**: 0 1 2 3 4 5 6 7 8 9 10 **Leg**: 0 1 2 3 4 5 6 7 8 9 10

Neck: 0 1 2 3 4 5 6 7 8 9 10 **Hand**: 0 1 2 3 4 5 6 7 8 9 10 **Foot**: 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below (*reference the KEY*), **where specifically you feel the pain** indicated above:

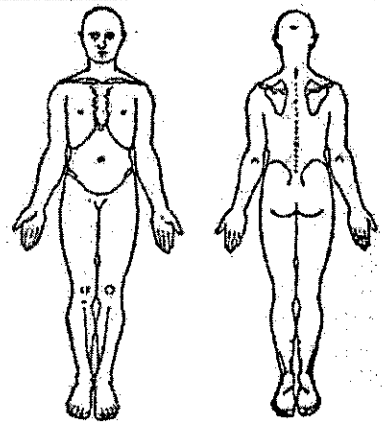
KEY

/ / / / / Stabbing

xxxxx Burning

00000 Pins & Needles

_____ Numbness



Do you **take any medications** (*If Yes, please fill out below or you may provide a list of your medicines*):

Prescription Medication	Dosage	Frequency	Medicine Route
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection

Over the Counter Medications (*Please circle any OTC medications that you take regularly*): Aspirin / Ibuprofen, Antacids, Sleeping Aids, Cold Medicine, Cough Medicine, Allergy Relief, Laxatives, Vitamin/Herbal Supplements, Diet Pills

Do you **have allergies** to ❑ Latex ❑ Lidocaine ❑ Cortisone ❑ None Known ❑Other:
Are you **currently receiving home health** services or have you **within the last 4 weeks**? ❑Yes ❑No
Have you had any physical, occupational or speech therapy **this calendar year**? ❑Yes ❑No
Do you have a **family member** or **friend** who can assist you during your recovery and with your care? ❑Yes ❑No

What **goals** do you have for therapy? What do you **hope to accomplish**?

My **next appointment** with my doctor is on_____/_____/_____❑ No appt scheduled.

Patient Signature:	Date:
Reviewed Health History with Patient:	Date:

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Authorization and Guarantee

Patient Name:	**Patient ID:**

INSURANCE BENEFITS (if applicable) :: As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable) :: "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients):: "In consideration of services rendered to me by PINNACLE Physical Therapy, I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with PINNACLE become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance."

RETURNED CHECKS :: We are happy to accept your personal check, however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

CONSENT FOR TREATMENT :: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at PINNACLE Physical Therapy."

WAIVER AND RELEASE :: "I hereby release, discharge and acquit PINNACLE Physical Therapy, it's agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

AUTHORIZATION TO RELEASE MEDICAL INFORMATION :: "I consent to allow PINNACLE Physical Therapy, to use and disclose my protected health information (PHI) within PINNACLE to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing."

ASSIGNMENT OF BENEFITS :: "I authorize my health plan to pay benefits directly to PINNACLE Physical Therapy, LLC. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider PINNACLE a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient."

NOTICE OF PRIVACY :: "I acknowledge that a copy of the Notice of Privacy Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

Patient / Legal Representative Signature ✗	Date:

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Cancellation/No-Show

Patient Name:	**Patient ID:**

Welcome to Pinnacle Physical Therapy!

We work hard to stay on schedule because your time is valuable to us! Staying on schedule also allows us to provide you with the appropriate amount of time with your therapist to maximize the benefits of therapy and give you the best possible outcomes.

Some important reminders regarding your scheduled appointments...

- **No Shows** - ** Please Note ** A $25 fee may be charged to your account for all missed appointments in which prior notice of a cancellation was not provided to the clinic within 24 hours of your scheduled appointment.
- **24 Hour Notice!** - If you have to cancel an appointment, please provide us with at least 24 hours notice. Failure to do so may result in a $25 charge being applied to your account.
- **Running Late?** - Please arrive on time for your scheduled appointments. If you are running late, please call ahead and let us know.
- **15+ Minutes Late?** -If you are running more than 15 minutes late, every attempt will be made to accommodate you. Your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.
- **Frequent Cancelled or Missed Appointments** - If you regularly cancel or miss your appointments, we may ask that you return to your referring physician prior to scheduling any more therapy.

Thank you for your understanding and we are looking forward to serving you!

A COPY OF THE **CANCELLATION & NOW SHOW** POLICY IS AVAILABLE UPON REQUEST.

Patient / Legal Representative Signature ✘	Date: