NEW PATIENT INFORMATION
(Please Print)

PATIENT NAME: _____MALE FEMALE (circle one)

ADDRESS: _____CITY:_____ST: _____ ZIP_____

EMAIL ADDRESS: _____DOB: _____

HOME PHONE: _____WORK: _____CELL: _____

Married: _____Single: _____ Divorced: _____ Widowed: _____

SOCIAL SECURITY NUMBER: _____

INCASE OF EMERGENCY, NOTIFY: _____ Phone:_____

RELATIONSHIP TO YOU: _____

Are you employed: _____yes _____no If yes how many hours per week: _____ full duty or light duty

Do you give us permission to email you about your appointments: _____yes _____ no

Do you give us permission to text you about your appointments: _____yes _____no

May we leave a message on your answering or voice mail: _____yes _____ no

Do you give us permission to discuss your medical condition with another person: _____yes _____ no

AUTHORIZATION FOR TREATMENT: I give my consent to undergo examination and treatment by the staff at Pinnacle Performance Physical Therapy
AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS: I authorize the release of any information required to act on this claim and permit photographic or further facsimile reproduction of this authorization to be used in place of the original. I hereby assign to Pinnacle Performance Physical Therapy LLC the medical benefits I am entitled to for Physical Therapy service from my insurance company. I AM RESPONSIBLE for any charges not paid by my insurance company.

PATIENT'S SIGNATURE _____DATE: _____

Medical History

Todays Date: ***Patient Name:***

General Information

1. Is this injury related to? ☐Work ☐ Car Accident☐ Other Liability/Potential Lawsuit ☐Not Applicable
2. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes

If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes

If you are a Medicare beneficiary, you are required by Medicare to answer the following question:

4. Do you consume more than 7 alcoholic drinks in a week? ☐ Yes ☐ No
5. Height _____ Weight _____

6. Did you have surgery? _____ A. Where: _____ B. When: _____
C: What part of you body: _____D. What procedure was done: _____
7. Have you had home health? _____ When? _____

Please Mark One Box For Each Item	No	Yes Under a year	Yes Over a year	No Answer /Invalid	**Please Mark One Box For Each Item**	No	Yes Under a year	Yes Over a year	No Answer /Invalid
Smoking	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Metal implants / pacemaker	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Head Injury	☐	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Chronic pain/fibro/headaches	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
					Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS/Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐Spine☐ Upper Extremity ☐Lower Extremity

Medical History

Today's Date: ***Patient Name:***

Patient Medication List

Please list ALL medications (including prescription, over –the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration

PINNACLE PERFORMANCE PHYSICAL THERAPY
2023 PATIENT SIGNATURES

PATIENT NAME: _____

Privacy Policy Acknowledgment

I understand that Pinnacle Performance Physical Therapy will not release my information to anyone without my permission and follow rules set forth by HIPPA. (If you would like a copy of the full privacy policy, please ask a staff member for a copy)

Financial Responsibility

I understand that payment is due in full when services are rendered. If and when you receive a billing statement payment is due in full upon receipt. Failure to make payment when due can result in the account being turned over to a collection agency and I am responsible for paying interest and all costs of collection efforts including court costs, collection agency fees and attorney fees, in addition to your outstanding balance. I also understand there will be a $25.00 charge for any returned check and this amount is above the amount of the check and must be paid by money order or cash promptly.

Financial Hardship

We are in the business of helping people. Should you have some difficulty paying your bills, we will work with you to help you create a payment plan that is mutually agreed upon. Finance should not limit your health care decisions. Please contact our office at 423-869-9923.

Cancellation and No Show Policy

The time of the therapists at Pinnacle Performance Physical Therapy is valuable, as is your time. We kindly ask for a minimum of 24 hours notice for any cancellations or rescheduled appointments. We understand that sometimes it is difficult to plan for the unexpected and therefore, we will allow leeway for the first two (2) no show appointments.

Following two (2) no show appointments, based on the decision of your therapist, you may either:

Pay $30.00 per NO SHOW appointment, based on the decision of your therapists, you may either:
OR
Be discharged from Physical Therapy

Please sign indicating that you were made aware of our procedures including missed visits.

Patient or Guardian Signature _____**Date** _____

Authorization for Release of Medical Records expires 12-31-2023

Patient Name _____Date of Birth _____

Address _____

_____

I hereby authorize the following people, businesses and/or establishments to release and have access to my medical records including history and diagnostic testing reports.

PINNACLE PERFORMANCE PHYSICAL THERAPY

PO Box 74 Harrogate, TN 37752

Phone: 423-869-9923

Fax: 423-869-9925

- _____
- _____
- _____

Signature of Patient _____ Date _____

Witnessed By _____ Date _____