LONE PEAK
PHYSICAL THERAPY

Move Better • Feel Better • Live Better

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female

SSN: _____ Email Address: _____ ☐ I would like to receive email updates

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

GUARANTOR / SPONSOR / LEGAL GUARDIAN INFORMATION

Guarantor Name: _____ Date of Birth: ___/___/___ SSN: ___-___-___

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____ Other Phone: _____

REFERRAL INFORMATION *(Check the one that applies)*

☐ Friend/Acquaintance: _____ ☐ Facebook ☐ Instagram ☐ Google ☐ Physician

WORKMAN'S COMP OR MOTOR VEHICLE ACCIDENT INFORMATION *(If applicable)*

Insurance Company: _____ Claim Number: _____

Adjuster Name: _____ Phone: _____ Fax: _____

- We accept cash, check, Visa, Mastercard, Discover & American Express.
- Payment plans are available. Interest at 12% per year will be charged if not paid off within a year of the date of service.
- If you are unable to keep your appointment, please provide 24 hours notice; there will be a charge of $50.00 for late cancellations or no-shows. This fee will be charged to you, not your insurance company.
- If it becomes necessary to send your account to collection for non-payment, you will be responsible for all collection and legal fees incurred.

GUARANTOR/SPONSOR INFORMATION

1. I understand that I am financially responsible for payment in full for all charges incurred regardless of insurance coverage. Further, I understand that Lone Peak Physical Therapy, Inc. has no contracted agreement with any private insurance companies as those agreements are between the patient and his or her insurance company.
2. I understand that dry needling may be deemed as medically unnecessary by my insurance company and that I am responsible for the $54.00 fee if insurance does not provide coverage for this service.
3. I hereby authorize payment directly to Lone Peak Physical Therapy Inc., from my insurance company, benefits otherwise payable to me, such payment not to exceed Lone Peak Physical Therapy's regular charges for the services performed.
4. If Lone Peak Physical Therapy bills my insurance directly, I agree to pay any charges deemed "patient responsibility" within my individual insurance plan.
5. If I am unable to pay my billed statement balance in full, a payment schedule will be implemented on the unpaid balance. All dates of service older than a year will be charged an interest rate of 12% APR. I also acknowledge that monthly payments are required to keep accounts active.
6. I understand that there may be some therapy equipment that will not be covered by my insurance company. I agree to pay for the items not covered at the time they are dispensed.
7. I understand that the fee for a returned check is $10.00.

CONSENT FOR TREATMENT

I hereby authorize Lone Peak Physical Therapy to administer and perform procedures deemed necessary or advisable to treat me / the patient.

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

I acknowledge that I have been informed about Lone Peak Physical Therapy's Notice of Information Practices (how my medical information may be used and disclosed and how I get access to that information). I have seen and read this Notice, and that I have been offered a copy of the Notice for my records.

I authorize Lone Peak Physical Therapy to release the necessary information requested for insurance or legal purposes, or as requested by an authorized physician. I also authorize release of information from physicians or other health care facilities to Lone Peak Physical Therapy as needed for physical therapy records.

I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to disclosure of suchinformation.

Print Patient Name: _____ Patient or Guarantor Signature: _____ Date : ____/____/____

As validated by my signature on this form, I certify that I have read and understand the above information.

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Why you are seeking treatment

Name:

Body Part:

Injury *(check one)*:
☐ Left ☐ Right ☐ Bilateral

Date of Injury: ___/___/___

Date of Surgery: ___/___/___

Next Appt with Doctor: ___/___/___

Referring Physician:

1. What medications are you currently taking?

2. Please rate your pain on a scale from 0 to 10:

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

no pain *moderate pain* *severe pain*

3. Do you smoke oruse tobacco? ☐ Yes ☐ No

4. Have you been diagnosed with or experienced any of the following *(check all that apply)*?

- ☐ Allergies
- ☐ Balance problems
- ☐ Bowel/Bladder problems
- ☐ Cancer, *type:* _____
- ☐ Cardiac Condition
- ☐ Chills/Fever/Sweats
- ☐ Depression
- ☐ Other: _____
- ☐ Diabetes
- ☐ Dizziness
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Night Sweats
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Psychological condition
- ☐ Pregnant/possibly pregnant
- ☐ Recent weight loss/gain
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Condition
- ☐ Weakness

5. Previous Injuries/Surgeries: