LONE PEAK
PHYSICAL THERAPY

Move Better • Feel Better • Live Better

PERSONAL INFORMATION

Name: | Age: | Date of Birth: | Sex: ☐ Male ☐ Female

SSN: | Email Address: | Gender:

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

☐ Other_____ ☐ Physician ☐ Return

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 no 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

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.

AUTHORIZATION FOR COMMUNICATION

By providing my above contact information and signing below, I consent and authorize Lone Peak Physical Therapy and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to

1. provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or
2. provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Lone Peak Physical Therapy or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Lone Peak Physical Therapy immediately of any change in telephone number or email address

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 such information.

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 or use 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: