ALPINE
PHYSICAL THERAPY

Personal Information

Patient Name:_____ Today's Date:_____
Last First M.I

Address: _____
Street City State ZIP

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Gender Non-Conforming/Non Binary

Marital Status: ☐ Married ☐ Single ☐ Other

Date of Birth: _____ Phone Number: _____

Employer:_____ Job Title: _____

Email: _____

By providing your email address you are giving consent to receive emailed statements and other correspondences which may include financial or diagnosis information. You acknowledge that electronic transmissions may not be a secure form of communication.

Emergency Contact:_____ Phone:_____ Relation:_____

Referring Doctor/Dentist: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about our office? _____

Do you have a referral? ☐ Yes ☐ No ☐ MD faxed in

Insurance Information:

Primary Insurance Company: _____ Provider Phone: _____

Identification Number: _____ Group Number: _____

Secondary/Supp Insurance Company: _____ Provider Phone: _____

Identification Number: _____ Group Number: _____

If treatment relates to an Auto or Work related injury, please fill out the remaining information below.

Insurance Company: _____ Date of Accident: _____

Claim Number: _____

Claim Manager's Name: _____ Phone: _____

If L&I – Patient's Employer & Address: _____

Clinical Information

Primary Concern: _____ Date of Onset: _____

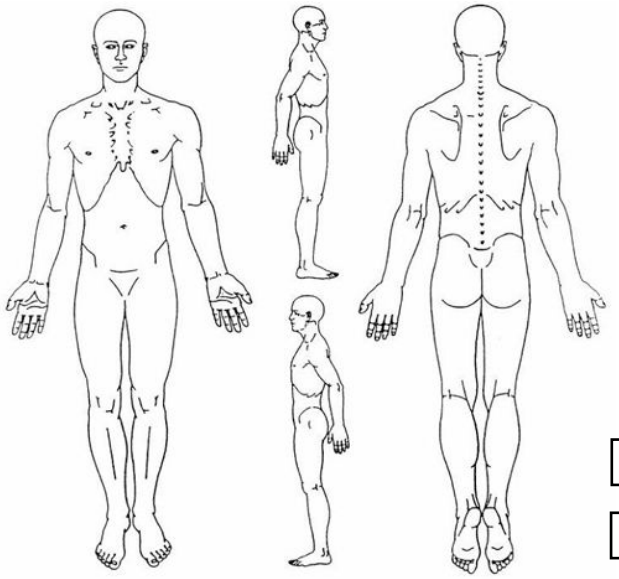
Secondary Concern: _____ Date of Onset: _____

Have you had any imaging? _____ Date of Imaging: _____

Was surgery performed? _____ Date of Surgery:_____

Height: _____ Weight: _____ Handedness: ☐ Right ☐ Left

Current Medications: _____



Please circle on the picture to your left the location where you are feeling discomfort/pain.

On a scale of 1-10 how would you rate your overall pain level?
0 = No Pain 10 = Most Extreme Pain

Primary: At Worst: _____ Current: _____ At Best: _____

Secondary: At Worst: _____ Current: _____ At Best: _____

How would you describe your pain?

☐ Ache ☐ Dull ☐ Sharp ☐ Burn

☐ Deep ☐ Shooting ☐ Superficial ☐ Numbness

☐ Tingling ☐ Worse In AM ☐ Worse in PM ☐ Other

What activities makes your pain/symptoms worse? Please list:

_____

_____

What activities makes your pain/symptoms better? Please list:

_____

_____

What activities/hobbies do you do regularly and/or enjoy doing?

_____

_____

What goals do you have for physical therapy?

_____

_____

Clinical Information

General Health:

Do you have, or have had, any of the following?

Cancer? ☐ Yes ☐ No
Diabetes? ☐ Yes ☐ No
Pregnant (currently) ☐ Yes ☐ No
Metal Implants? ☐ Yes ☐ No
High Blood Pressure? ☐ Yes ☐ No
Seizures? ☐ Yes ☐ No
Concussion? ☐ Yes ☐ No
Falls? ☐ Yes ☐ No

Neck/Jaw/Head

Do you experience facial pain? ☐ Yes ☐ No
Do you feel a click or a pop when you open or close your mouth? ☐ Yes ☐ No
Do you experience weekly headaches? ☐ Yes ☐ No
Do you wake up with dry mouth? ☐ Yes ☐ No
Do you feel pain in the front of your ear, or feel ringing? ☐ Yes ☐ No
Do you have a dental appliance? ☐ Yes ☐ No
Do you have a history of orthodontia or Invisalign? ☐ Yes ☐ No

Breathing

Do you snore? ☐ Yes ☐ No
Do you feel tired after a full night of sleep? ☐ Yes ☐ No
Do you have asthma? ☐ Yes ☐ No
Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Sensitivities:

Latex Allergy ☐ Yes ☐ No
Light ☐ Yes ☐ No
Sound ☐ Yes ☐ No
Taste ☐ Yes ☐ No
Smell ☐ Yes ☐ No
Food Allergies: ☐ Yes ☐ No
Other: _____

Vision

Do you wear contacts? ☐ Yes ☐ No
If yes, what's your prescription? _____
Do you wear glasses? ☐ Yes ☐ No
If yes, what's your prescription? _____
Do you wear progressives? ☐ Yes ☐ No
Do you have difficulty driving at night? ☐ Yes ☐ No
Do you have blurry or double vision? ☐ Yes ☐ No
Do you feel dizzy? ☐ Yes ☐ No
Do you feel lateral leg & ankle strain, Back tightness, or pain at the bottom of one or both feet? ☐ Yes ☐ No
Have you had Lasik eye surgery? ☐ Yes ☐ No

Feet

Do you have flat feet? ☐ Yes ☐ No
Do you have orthotics, heel lifts, or any other foot inserts in your shoes? ☐ Yes ☐ No
Do you feel unstable with one or both of your ankles? ☐ Yes ☐ No
Do you have a history of ankle instability or sprains? ☐ Yes ☐ No

Lubo/Pelvic

Do you ever experience small amounts of urine leakage? ☐ Yes ☐ No
Do you ever experience pain, discomfort or pressure in your pelvic area ☐ Yes ☐ No
Do you experience any numbness or tingling in your lower body? ☐ Yes ☐ No
Do you have pain radiating past your hips? ☐ Yes ☐ No

Mental Health

Anxiety? ☐ Yes ☐ No
Depression? ☐ Yes ☐ No
Bipolar Disorder? ☐ Yes ☐ No
PTSD? ☐ Yes ☐ No
Other: _____

ALPINE
PHYSICAL THERAPY

Informed Consent and Release
ALPINE PHYSICAL THERAPY, PLLC

Financial Policy: As a courtesy, we will bill the primary insurance company for our patients, if we are provided the necessary information. This also includes Personal Injury Protection claims (PIP) and the state (L&I or private Worker's Compensation, Medicare and Medicaid). Co-payments are due at the time of each visit. It is important to communicate any financial problems as soon as possible. Please contact the business office directly to discuss a mutually agreeable payment plan so you will not jeopardize your credit.

- Your insurance is a contract between you, your employer (if applicable) and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what their insurance company allows for therapy, obtain prior approval (if necessary) and follow up with their insurance company on all unpaid visits.

Should your insurance deny payment or coverage for any reason, you are responsible for any and all charges billed. A statement will be emailed/mailed to you after the denial has been received from your insurance company. This notice will hold for duration of your treatment for this injury. These denials may include, but are not limited to

- Medical Necessity
- Required Documentation Missing
- Investigational Coding
- Processing Dispute
- Exceeds Plan Limits

Patient Consent and Release: I understand that I am financially responsible for all charges for service rendered regardless of litigation, insurance reimbursement or pending L&I claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I request and consent to the performance of evaluation, treatment and procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time.

I authorize Alpine Physical Therapy, PLLC to release any necessary information requested by my insurance carrier and authorize payment directly to Alpine Physical Therapy, PLLC for any benefits available under my insurance plan.

Cancellation Policy: We require 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or do not show for your scheduled appointment, an administrative fee of $50.00 will be billed to you.

_____ _____

Signature of Patient Date

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Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Alpine Physical Therapy, PLLC.

This form will be retained in your medical record.

_____ _____
Signature of Patient (or Representative*) Date

*If this acknowledgement is signed by a personal representative on behalf of the patient, then please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify.) _____

_____ _____ _____
Signature of Witness (Employee) *Printed* Employee Name Date

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PRI INFORMED CONSENT FOR MANUAL THERAPY

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Alpine Physical Therapy. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from our services. Therefore, if "hands-on" manual or exercise techniques that are being used to retrain, recruit and restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

I have read this form and fully understand and accept its terms and conditions.

_____	_____	_____
Signature of Patient (or Representative)	*Printed* Name	Date
_____	_____	_____
Signature of Witness (Employee)	*Printed* Employee Name	Date