
PERSONAL INFORMATION

Name:	Age:	Date of Birth:	Sex:
_____	_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
SSN:	Email Address:	<input type="checkbox"/> 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:
_____	_____	_____	_____

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 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.
3. If Lone Peak Physical Therapy bills my insurance directly, I agree to pay any charges deemed "patient responsibility" within my individual insurance plan.
4. 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.
5. 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.
6. 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 such information.

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.

WHY YOU ARE SEEKING TREATMENT

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)?

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

5. Previous Injuries/Surgeries: