Welcome! to Summit Physical Therapy, Inc.

(PLEASE PRINT)

NAME_____ TODAY'S DATE_____
Last First MI

ADDRESS_____ APT#_____ HOME PH#_____
Preferred ☐

CITY_____ ST_____ZIP_____ CELL PH# _____
Preferred ☐

SEX ☐ M ☐ F AGE_____ BIRTHDATE____ / _____ /_____ EMAIL: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

HOW DO YOU WANT TO RECEIVE APPOINTMENT REMINDERS? ☐ TEXT ☐ EMAIL ☐ AUTOMATED CALL ☐ NONE

EMERGENCY CONTACT NAME_____ RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT'S BEST PHONE NUMBER _____

****

IS THE PATIENT A MINOR? ☐ NO ☐ YES IF SO, RESPONSIBLE PARTY_____

RESPONSIBLE PARTY BIRTHDATE ____ /_____ /_____ RELATIONSHIP TO PATIENT_____

****

PRIMARY INSURANCE CO_____ ***PLEASE PROVIDE CARD TO BE COPIED***

SUBSCRIBER (IF OTHER THAN YOU) NAME_____ DOB_____ /_____ /____

SECONDARY INSURANCE CO_____ ***PLEASE PROVIDE CARD TO BE COPIED***

SUBSCRIBER (IF OTHER THAN YOU) NAME_____DOB_____ /_____ /_____

****

DOES YOUR TREATMENT NEED RELATE TO AN INJURY BEING COVERED BY AN OPEN WORK COMP CLAIM? ☐ NO ☐ YES
DOES YOUR TREATMENT NEED RELATE TO AN INJURY BEING COVERED BY AN OPEN AUTO ACCIDENT CLAIM? ☐ NO ☐ YES

IF YES TO EITHER, DATE OF INJURY _____ /_____ /_____ INSURANCE CO_____

CLAIM#_____ ADJUSTER NAME_____

ADJUSTER PH#_____ ADJUSTER FAX#_____

****

How did you hear about us?

☐ RECOMMENDED BY DR._____ ☐ REFERRED BY FRIEND/FAMILY ☐ I AM A FORMER PATIENT

☐ NETWORK PROVIDER LIST ☐ WEBSITE/ONLINE SEARCH ☐ WORD OF MOUTH ☐ SIGN/DROVE BY

ASSIGNMENT & RELEASE OF BENEFITS:
I hereby assign all benefits from the above-named insurance(s) to be paid directly to Summit Physical Therapy for services rendered. I authorize the use of my signature on all insurance submissions. Summit Physical Therapy may use my healthcare information and may disclose such information to the above-named insurance company(ies) for the purpose of obtaining payment and for determining insurance benefits or the benefits payable for related services.

_____ _____
SIGNATURE PRINTED NAME

****

(FOR OFFICE USE ONLY) VERIFICATION OF DEMOGRAPHICS/NO CHANGE: (FOR FUTURE VISITS)

_____ _____ / _____ _____ / _____ _____
DATE INITIALS / DATE INITIALS / DATE INITIALS

SUMMIT PHYSICAL THERAPY
Policies & Procedures

****Please initial beside each section, and sign and date below.****

____ Cancellations:

Three people are affected when you miss an appointment without notice. You don't get treated, another patient misses an opportunity to be seen, and the therapist has a gap in his schedule. Our 24-hour voicemail can take your cancellation call at any time, even when the office is closed. ***Please give us a timely notice, preferably 24 hours in advance. Short cancellations and no-shows will incur a $35.00 charge.***

_____ Co-pays & Deductible:

Insurance co-pays are due at the time of service. If you have an insurance deductible due, you will be asked to pay a minimum of $50.00 towards that amount at the time of service. Any additional balance will be billed to you after the insurance has completed their processing. We have a returned-check fee of $25.00.

_____ Financial Responsibility:

We bill your insurance as a courtesy, and will work with the insurance to resolve any denied claims or problems. ***However, ultimate responsibility for payment of services rests with the patient.*** We are always happy to work with you on payment plans during times of financial hardship, but accounts that become past due without any effort towards payment will be assigned to an outside collection agency, which may adversely affect your credit rating.

_____ Privacy:

Summit Physical Therapy is committed to maintaining your privacy and protecting your personal health information. Your signature below indicates your acknowledgement that you have received a copy of our Patient Privacy Policy.

_____ Release of Information:

Your signature below authorizes us to exchange any information necessary for your treatment with other medical providers involved in your care, including but not limited to history obtained, x-ray and physical findings, diagnosis and prognosis, and record of current treatment plan.

****

_____ _____

Signature Date

_____ _____

Printed Name Relationship to patient (if other than self)

Vestibular Intake Form

Name:_____ Date:_____

Please circle the symptoms that bring you to therapy today:

Dizziness	*Lightheadedness*	*Disorientation*	*Vertigo/Spinning Sensation*	*Decreased Balance*
Headache	*Facial Numbness*	*Ringing in the Ears*	*Difficulty with Memory*	*Rocking/Swaying*
Nausea	*Fatigue/Weakness*	*New Hearing Loss*	*Visual Disturbances*	*Passing Out/Fainting*

Date Problem Began: _____ **Are the symptoms:** *Getting better* *Getting worse* *Staying the same*

How long do they last: *Seconds* *Minutes* *Hours* *Days* *Weeks*

How often do they occur? *Daily* *Weekly* *Monthly* *Longer Intervals:* _____

Did they come on: *Suddenly* *Gradually* *Overnight* *I'm not sure*

Are the symptoms: *Constant* *Come and go* *Triggered by specific movement or activity*

Symptoms Increase with: *(circle all that apply)*

Rolling over in bed	*Turning your head*	*Walking*	*Bearing down/Straining*
Lying to sitting	*Sitting to standing*	*Driving*	*Bending/Squatting*
Looking up/down	*Lying down*	*Reading*	*Coughing/Sneezing*
Loud Noises	*Crowds*	*Other*_____	

In the past week, what percentage of time has dizziness interfered with your daily activities? _____%

Have you had any tests for this problem? (MRI, hearing test, etc):_____

Have you had any falls? If so, when?_____

Do you feel unsteady and/or have a fear of falling? _____

Please list your current medications:_____

_____

_____

Summit Physical Therapy
Patient Privacy Policy

Effective Date April 14, 2003

WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH A DETAILED WRITTEN NOTICE DESCRIBING HOW THIS CLINIC MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN OBTAIN OR CORRECT THIS INFORMATION.

Here is a brief summary:

- We may use your medical information or disclose it to others in order to provide or arrange your health care, to arrange payment or reimbursement for the care that we provide to you, or to carry out administrative activities related to or supporting your treatment.

- We may be required or permitted by certain state or federal laws, regulations, or legal circumstances to use or disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

- As our patient, you have important rights regarding your medical information in this clinic. You have the right to inspect, copy, amend or correct that information, obtain an accounting of disclosures of your medical information, request that we communicate with you confidentially and request that we restrict certain uses and disclosures of your health information. We have a procedure for filing a complaint if you think your rights have been violated.

- A detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law is posted on our website at https://summit-physicaltherapy.com/notice-of-privacy-practices/ .We may revise our notice from time to time. The effective date at the top of this page indicates the date of the most current notice in effect.

- You have the right to receive a written copy of our most current notice in effect. If you would like to receive a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the notice or your medical information, please contact Paul Kane of our office at (503) 699-2955.