SUMMIT
PHYSICAL THERAPY, INC

Name: _____DOB: _____ Date: _____

What is the reason for your visit? _____
When did the problem start? _____
How did the problem occur? _____
Please indicate which side of your body this problem exists: Right Left Both
Are you receiving other treatment for this condition? Yes No
If yes: what treatment, where, and by whom: _____
Have you ever had imaging? ____ Yes No
Type of Imaging: _____ Where Completed: _____
Have You had Surgery Recently? Yes No Date of Surgery: _____
Type of Surgery: _____
Have you Had any falls in the past month? Yes No How many falls have you had in the last 6 months? _____
Are you allergic to latex? Yes No

Medical History Have you or do you have any of the following (please circle all that apply)?

Alzheimer's Disease	History of Cancer	Asthma
Cardiovascular Disease	Huntington's	Chest Pains
Cauda Equina Syndrome	Immunosuppression	Depression
Cerebral Vascular Accident	Lupus	Multiple Sclerosis
Current Infection	Muscular Dystrophy	Vertigo
Diabetes Mellitus Type 1	Obesity	Vision Loss
Diabetes Mellitus Type 2	Osteoarthritis	Unexplained Weight Change
Fibromyalgia	Parkinson's	
Fracture or Suspected Fracture	Rheumatoid Arthritis	
High Blood Pressure	Traumatic Brain Injury	

Other: (please specify)_____
Are You Currently Pregnant? Yes No If yes, how many weeks along? _____

Surgical hx:
Surgery performed: _____Body Region: _____Date: _____
Surgery performed: _____Body Region: _____Date: _____

Medications
Type:_____Reason:_____Dosage:_____Frequency:_____
Type:_____Reason:_____Dosage:_____Frequency:_____
Type:_____Reason:_____Dosage:_____Frequency:_____

Have you had Physical Therapy in the past? Yes / No
If Yes, please indicate what you were seen for and when:_____

What are your current physical therapy goals? 1._____2._____

Please list 3 activities that you have the most difficulty performing. Please rate your ability level to complete this activity:
0% means you are completely unable to complete the activity 100% means you can complete the activity without difficulty.

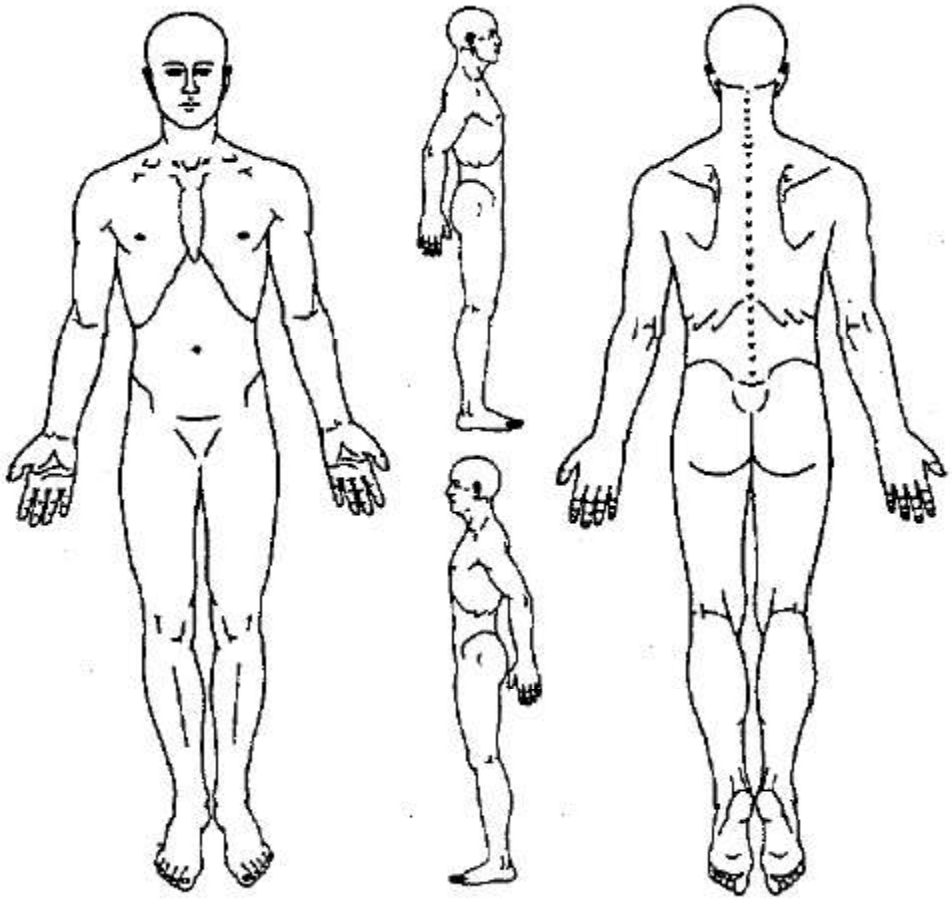
Activity 1: _____ Level: ___/100%

Activity 2: _____ Level: ___/100%

Activity 3: _____ Level: ___/100%

1. On the diagram, mark where you are experiencing pain right now. Use the letters below to indicate the type and location of your sensation.

A – Ache B – Burning N – Numbness P – Pins/Needles S – Stabbing O – Other



2. Rate the severity of pain by checking one box in the scale below.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

What percentage of your day do you have pain? (please circle):

0-25% **26-50%** **51-75%** **76-100%**

Is there anything else you would like your therapist to know?

_____

_____

_____

_____

NEW PATIENT INTAKE

Patient's Name: _____ Today's Date: _____
Address: _____City: _____State: _____ Zip: _____
Phone: C: (____)_____ H: (____)_____ W: (____)_____
Email: _____
SS#: _____ DOB:_____ Gender: _____ Marital Status: M S W D

Preferred contact for visit reminders (please circle one):
Email

Voice Call:	Cell Phone	Home Phone	Work Phone
Text Message:	Cell Phone	Home Phone	Work Phone

Custody Status (for minors only): Mother Father Joint Custody Legal Guardian Other: _____

Referring Physician:_____ Primary Care Physician (if different): _____
Prescription from Doctor? Yes No

Emergency Contact Name: _____ Emergency Contact Phone Number: (____)_____

Please list those individuals to whom we are authorized to disclose your private health information (this includes discussing scheduling, treatment, and billing). You do not need to list your doctors. If you would like any private health information shared with your emergency contact in a non-emergency, please list them here as well: _____
_____

If you would like to limit the information given to them, please specify here (i.e. only scheduling information):
_____

How did you hear about Summit Physical Therapy, Inc.? _____

Are you a Full Time Student? Yes No
Employer:_____ Address:_____ Job Title: _____

Is Patient the Responsible Party? Yes No
If no: Responsible Party Name:_____ Relationship to patient:_____
Address: _____SS#:_____-_____-_____ DOB:_____

Is this a work- related accident / injury? Yes No Date of Injury: ___/___/___ If Surgery, the date: ___/___/___
Employer at time of injury: _____*Phone #:* _____
Address: _____
*Work Comp. Provider Ins .:*_____ *Phone #:*_____
*Work Comp. Claim #:*_____ *Adjuster:*_____
Have you returned to work? Yes No Please list work restrictions, if any: _____
_____

Was this injury caused by a motor vehicle accident? YES / NO Please list details of accident: _____
_____
_____

Insurance Information

Primary Insurance Co: _____ Group#:_____ Id#: _____
Primary Insured Party Name:_____ DOB: _____ SS#:_____:_____:____
Relationship to patient: _____ Phone #: _____
Address: _____

Secondary Insurance Co: _____ Group#:_____ Id#: _____
Primary Insured Party Name:_____ DOB: _____ SS#:_____:_____:____
Relationship to patient: _____ Phone #: _____
Address: _____

Have you had Physical Therapy or Speech Therapy this year? Yes No
If yes, where? _____

I, the patient, do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment as ordered by the prescribing physician, and his/her assistant(s), and consultant(s), as is necessary in his/her professional judgment. I assume responsibility for discussing and understanding my proposed treatment and goals based on the evaluation with my physician, as well as expected benefits and potential risks and drawbacks of the evaluation and service, and understand treatment does not guarantee an improvement in my current condition.

Please initial _____

I hereby authorize Summit Physical Therapy, Inc., its employees or agents, to release medical information regarding myself and my current condition(s) to my insurance company for purposes of payment and/or quality reviews; and referring, consulting, treating physicians, or other medical providers as necessary to support continuity of care. This authorization will remain valid until mutually revoked in writing by both the patient and Summit Physical Therapy, Inc. I understand that Summit Physical Therapy, Inc. has made a copy of their Notice of Privacy Practices available for my review, and that I can request a copy at any time in writing or by contacting a Summit Physical Therapy, Inc. office representative. I authorize Summit Physical Therapy, Inc. to utilize my contact information, such as email addresses or phone numbers, to correspond with me information that is not considered Protected Health Information (PHI).

Please initial _____

I, understand that I am responsible for communicating with my insurance company regarding any co-payments, deductibles, or provider information pertaining to my treatment at Summit Physical Therapy, Inc. I understand that I am responsible for obtaining any required referrals from primary care clinics. I understand I am ultimately responsible for any charges not covered by third party payers. I attest that I am not currently receiving or enrolled in home health services. I agree to notify Summit Physical Therapy, Inc. in writing if I begin home health services, and acknowledge that failure to notify Summit Physical Therapy, Inc. in writing will result in my being financially responsible for services rendered.

Please initial _____

I agree I am responsible for notifying Summit Physical Therapy, Inc. within 30 days of change in insurance coverage, or termination of existing coverage. If I fail to do so within that timeframe, I will be responsible for the full balance due for services rendered. If I notify Summit Physical Therapy, Inc. of new insurance after services have already been rendered, and the new insurance will not cover services due to plan-level requirements not being met (such as but not limited to MD Orders, Prior Authorization), I agree to be responsible for the full balance due of services rendered.

Please initial _____

If applicable, I authorize third party payment directly to Summit Physical Therapy, Inc. of the benefits otherwise payable to me. Those charges are not to exceed charges incurred. If I have instigated litigation due to my injury and refuse to provide the appropriate insurance information, I understand that I am required to pay Summit Physical Therapy, Inc. at the time services are provided. I also understand that if I have filed a Workers Compensation claim and my claim is denied, I will then be responsible for payment of services as they are received if I do not provide health insurance. I understand I am financially responsible to Summit Physical Therapy, Inc. for charges not covered by this authorization.

Please initial _____

I understand that all copayments, coinsurances, and deductibles are paid in full at the time of treatment unless previous arrangements have been made. I understand that if Summit Physical Therapy, Inc. is charged a fee due to a returned check, I agree that all fees are payable by the writer of the check to Summit Physical Therapy, Inc.

Please initial _____

I have read Summit Physical Therapy Inc.'s Privacy Practices Statement (or waive my right to read this document) and understand my privacy rights as they pertain to treatment at Summit Physical Therapy, Inc.

Please initial _____

The information submitted in this form is accurate to the best of my knowledge.

Patient Signature: _____ Date: ____/____/____

Print Patients Name: _____

Responsible Party Signature (if required): _____ Date: ____/____/____

Responsible Party Printed Name: _____

Relationship to Patient: _____

SUMMIT
PHYSICAL THERAPY, INC
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PH: 907-235-RISE FAX: 907-205-5370 WWW.SUMMITPTALASKA.COM

APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent physical therapy care to you, your family, and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for a patient. "No-shows" and late cancellations inconvenience those individuals who need access to care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancellation Policy and it is effective immediately. Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is 907-235-7473.

2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this a missed (no-show) appointment and a **$25.00 no-show fee** will be assessed to you. This applies to late cancellations and "no-shows." The no show fee may be waived if you are able to reschedule your appointment at time of cancel in order to maintain the same frequency of visits that week.

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. We have set up reminders if you have requested to receive them. *It is ultimately the patient's responsibility to remember his or her scheduled appointments.*

5. It is Summit Physical Therapy, Inc.'s policy that patients will be discharged due to noncompliance after 3 non-exempt cancellations or no-shows.
    a. Exempt cancellations include unforeseen circumstances/emergencies or illness.
    b. All other cancellations are non-exempt.

6. Any patient who is currently being seen for a Worker's Compensation case: the Worker's Compensation adjuster will be notified after 2 no shows or non-exempt cancellations as well as at the time of discharge due to noncompliance.

7. Any patient who is covered by VA/TriWest insurance: the VA/TriWest will be notified of cancel/no-shows.

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is due within 30 days of the cancelled appointment expected in a timely fashion and if not, will be subject to collections. If you do not pay this no-show fee within 30 days of the no-showed appointment, we are unable to schedule you for further appointments until this balance is paid. If you have 2 "no-show" appointments, then all follow up visits will be scheduled for 30 minutes.

I have read and understand the Appointment Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____

Printed Name

SUMMIT
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: