SUMMIT
PHYSICAL THERAPY

Summit Physical Therapy
1306 Macon Road Perry, GA 31069
P: 478-987-4600 F: 844-308-4986

Personal Information

Last Name	First Name	Age	☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Occupation _____ Employer Name _____ Employer Phone Number _____

Emergency Contact/Relationship _____ Phone Number _____ (IF MINOR) Parent/Guardian Signature _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

My condition is related to: ☐ Work ☐ Auto-Accident ☐ Other_____ Injury Date _____

Social Security #: _____ Date of Birth: _____ ☐ Single ☐ Married

How did you hear about us? _____

Primary Complaint: _____ Goals: _____

Have you been treated by another (PLEASE CIRCLE ALL THAT APPLY) physical therapist, occupational therapist, speech therapist, chiropractor, or Home Healthcare agency since January 1st of this year? ☐ Yes ☐ No
If yes, have you been discharged from their facility? ☐ Yes ☐ No
Primary Care Physician _____ Referring Physician _____

Primary Insurance Information

Name of Subscriber _____ Relationship to Subscriber _____
Subscriber DOB _____ Subscriber SSN _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Member ID _____ Group # _____
Insurance Company Address _____

Secondary Insurance Information

Name of Subscriber _____ Relationship to Subscriber _____
Subscriber DOB _____ Subscriber SSN _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Member ID _____ Group # _____
Insurance Company Address _____

The above information is true to the best of my knowledge. I, the undersigned, acknowledge that Summit Physical Therapy will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices (HIPAA).

Signed: _____ Date: _____

Summit Physical Therapy Medical Screening Questionnaire

Name: _____ DOB: _____ Date: _____

History

Age: _____ Sex: _____ Date of Onset: _____ Are you pregnant? _____

How did the injury occur?

_____

_____

Pain Location: _____ Pain Description: _____

Current Pain Rating (0-10): _____ At Best: _____ At Worst: _____

Positions that improve pain:_____

Positions that worsen pain: _____

Describe your regular activities: _____

Affecting Sleep: _____ Sleep Position: _____

Increased pain with (CHECK ALL THAT APPLY): ☐ Coughing ☐ Sneezing ☐ Deep Breathing ☐ Laughing

Do you have any barriers to learning? If so please list: _____

Past/Current Medical History (Please check all that apply):

☐ Cancer	☐ Diabetes: 1 OR 2 (CIRCLE)	☐ Kidney Disease	☐ Fibromyalgia
☐ High Blood Pressure	☐ Heart Disease	☐ Angina/Chest Pain	☐ Ulcers
☐ Osteoporosis	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Stroke
☐ Allergies/Asthma	☐ Lung Disease	☐ Liver Disease	☐ Seizures
☐ Multiple Sclerosis	☐ Smoke: Previously OR Currently (CIRCLE)		

☐ Other: _____

Do you take blood thinners? ☐ Yes ☐ No Are you allergic to latex? ☐ Yes ☐ No

Have you had a recent illness? _____

Orthopedic Injuries: _____

Past Surgical History (Please list with dates):

_____

_____

_____

Please list all current medications:

_____

_____

_____

Currently I am experiencing (Check all that apply):

☐ Fever/Chills/Sweats	☐ Poor Balance	☐ Unexplained Weight Loss
☐ Nausea/Vomiting	☐ Numbness/Tingling	☐ Changes in Appetite
☐ Shortness of Breath	☐ Dizziness	☐ Difficulty in Swallowing
☐ Changes in Bowel or Bladder Function	☐ Increased Pain at Night	☐ Headaches
☐ Depression		

IMPORTANT COMPANY POLICIES FOR A SUCCESSFUL RELATIONSHIP

Summit Physical Therapy strives to provide you with the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

INITIAL ALL BOXES

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule, wait for the next available opening, or your treatment time may be reduced.

☐ **Copays are due upon arrival**
We will file your insurance; however, you are responsible for paying your deductible, co-pay, and/or percentage at the time of service unless arrangements are made in advance. We accept cash, checks, and all major credit cards. There will be a $25.00 service charge for all returned checks. You may prepay for the week or at each appointment.

☐ **No-shows/Cancelation Fees**
Not showing for a scheduled appointment or canceling without a 24 hours' notice will result in a $25.00 charge that will be billed to you directly. If you fail to show or cancel for three consecutive visits, our font office staff will be required to remove all future appointments scheduled. Your physician and adjustor/case worker (if you under a worker's compensation claim) will be notified.

☐ **Insurance Changes**
It is your responsibility to notify our front office of all insurances and of any changes that may occur during your care. All charges that occur due to insurance conflicts will be the responsibility of the patient.

☐ **Consent for Treatment**
I consent to and authorize Summit PT (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my condition answered prior to treatment. I know it is my responsibility to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services are made.

☐ **Cell phones must be shut off or silenced**
We realize emergencies may arise and therefore allow you to carry your cell phone during your treatment. However, please be courteous and set it to silent mode or shut it off. Please refrain from carrying on phone conversations in treatment areas out of respect for other patients. Thank you.

☐ **Photo/Video Consent**
I authorize the use and disclosure of my name, photogenic/video images, and/or testimonial for marketing purposes by the practice, Summit Physical Therapy. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. (Our purpose in photo'ing/videoing is to show the progress you've made from your initial visit to your discharge visit.)

☐ **Dry Needling**
Dry Needling is not a covered service by insurances. However, it is a legal service that may be performed in the state of Georgia by licensed physical therapists who have been trained. We believe dry needling has many benefits and because of this, we will still perform the service. Since it is not a covered modality by insurances, you will be responsible for a $25.00 fee for the service if provided (as well as your copayment/deductible/coinsurance if you have one). Your physical therapist will go over DN if they believe you will benefit from it, and you will make the decision on whether or not you would like the service to be provided. A referral is required before the service can be provided.

I HAVE READ ALL OF SUMMIT PT'S POLICIES LISTED ABOVE.

Patient Signature: _____ Date: _____

Assignment of Benefits

For consideration of services rendered by Summit Physical Therapy, I hereby guarantee payment of all charges incurred by the above-named patient. I hereby authorize the payment of benefits of my insurance policy to be paid directly to Summit Physical Therapy for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, other physicians, hospitals, clinics or Summit Physical Therapy.

- I **Give/Do Not Give** (PLEASE CIRCLE) my permission to Summit PT to leave **Confidential** messages at:

  My Home #: _____ My Cell #: _____

- Consent for email communications: **Yes/No** (PLEASE CIRCLE)

- It is the patient's responsibility to keep personal items with them at all times.
- As a service to you, our office will bill your primary and secondary insurance companies for charges incurred. All deductibles, copays, and coinsurance balances will be due on the date services are rendered at check-in.
- We DO NOT file third party claims here at Summit Physical Therapy. If you are being seen in our office for injuries sustained in an auto accident, we will file your personal insurance and copays, coinsurances, & deductibles must be paid as if the treatment was not due to an auto accident.
- The parent or guardian accompanying a minor is responsible for payment of services at the time of check-in. Unaccompanied minors (under 18) still must have payment at the time of service unless the parent or guardian has signed patient and financial responsibility forms.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID OR COVERED BY MY INSURANCE COMPANY.

_____ _____

Patient Name (Please Print) Patient DOB

_____

Patient Signature

NON-INSURANCE PATIENTS

All patients without insurance will be required to pay in full at the time of service. Cash, checks, and all major credit cards will be accepted.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

_____

Responsible Party (If other than patient)

Summit Physical Therapy
1306 Macon Road Perry, GA 31069
P: 478-987-4600 F: 844-308-4986

Medical Information Release Form

Patient Name: _____ Patient DOB: _____

Release of Information ***(CHECK ALL THAT APPLY)***

☐ I authorize Summit Physical Therapy to release information including diagnosis, medical records, and appointment information to the following:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____

☐ Information is not to be released to anyone.

Records Release ***(CHECK ALL THAT APPLY)***

Records are to be released via:

- ☐ Phone _____
- ☐ Email _____
- ☐ Paper Copy _____

_____ _____

Patient Signature Date