2809 Route 88, Point Pleasant, NJ 08742
Phone: (732) 475 6745 Fax: (732) 475 7809

551 Route 35 N, Normandy Beach 08739
Phone: (732) 375-6170 Fax: (732) 375-6143

Email: info@PinnaclePhysicalTherapyNJ.com

Website: PinnaclePhysicalTherapyNJ.com

At Pinnacle, we offer more than just Physical Therapy! Which of our other Wellness Services would you like to learn more about?

[ ] Massage Therapy

[ ] Acupuncture

[ ] Nutrition & Wellness Coaching

[ ] Supplement Information

[ ] CBD Products

[ ] Compression Therapy

[ ] Stretching Packages

Shirt Size: S M L XL XXL

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Patient Information Form

Name _____ Birth Date _____
Social Security Number _____ Age _____
Address _____ Occupation _____
_____ Phone Number _____
_____ Alt. Phone Number _____
Email _____
Emergency Contact & Phone Number _____
How Did You Hear About Us _____
What Are You Coming For _____
Symptoms/Limitations _____

Insurance Information

Primary Insurance Company _____

Referring Physician _____ Phone Number _____

Primary Physician _____ Phone Number_____

Insurance Authorization & Assignment

All professional services are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments.

I hereby authorize Pinnacle Rehabilitation & Sports Medicine LLP to furnish information to insurance carriers concerning my illness, condition, disability, and treatment thereof. I hereby assign to the provider of this treatment all payments for services rendered to my dependents or myself. I understand and agree that my insurance company will be billed directly, and I am ultimately responsible for the balance of my account for any professional services rendered at Pinnacle Rehabilitation & Sports Medicine LLP. I hereby authorize direct payment to Pinnacle Rehabilitation & Sports Medicine LLP. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Patient/Guardian Signature _____ Date _____

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Medical History

Please circle all that apply:

Arthritis Artificial Heart Valve Asthma Cancer Diabetes Seizures

Difficulty Breathing Fainting Glaucoma Pacemaker Frequent Headaches

Heart Attack Stroke COPD Chest Pain Fractures

Neurological Issues High Blood Pressure Thyroid Issues

Please List Any Other Medical Conditions Not Listed Above

_____

_____

_____

Previous Surgeries

_____

_____

Allergies

_____

_____

Please List All Medications

_____

_____

_____

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Appointment Policy

Pinnacle Rehabilitation & Sports Medicine is dedicated to providing an excellent experience for everyone. If you find you are running late, we recommend that you call ahead to let us know. As a courtesy to others, we reserve the right to reschedule your appointment if you are more than 15 minutes late. If you miss 2 appointments without giving 24-hour notice, you will be charged a $25 fee. We will do our best to accommodate every situation.

Initials _____

Co-Pay Policy

All copays are expected to be paid before the start of each session.

Initials _____

Billing Policy

If your insurance is out of network and you receive the insurance checks directly, you have 7 days to bring in the check from the date you received it. If not, you will be billed the payment amount due immediately.

Initials _____

Consent to Treat

I give Pinnacle Rehabilitation & Sports Medicine permission to perform an evaluation, assessment and possible treatment for my condition.

Initials _____

Thank you so much for understanding and cooperation.

_____ _____

Signature Date

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information, including the diagnosis, records, examination rendered to me, claims information and video/photo documentation. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] cell number: _____

If unable to reach me:
[ ] you may leave me a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time) _____

_____ _____

Patient/Patient Guardian Signature Date

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Photo Release Form

I, _____, give permission for Pinnacle Rehabilitation & Sports Medicine to photograph and videotape portions of my physical therapy and/or acupuncture session and for this information to be used:

[ ] On social media for advertising and promoting

[ ] In the care and planning of my therapy treatment

[ ] I do not want to be photographed or videotaped

_____ _____

Signature Date

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Parent/Guardian Consent

For those 17 & under

I, _____, give Pinnacle Rehabilitation & Sports Medicine

permission to treat _____ for Physical Therapy Services.

Guardian Printed Name _____ Relation _____

_____ _____

Signature Date

I do / do not give Pinnacle Rehabilitation & Sports Medicine permission to treat my child,

_____, when I am not present. I understand that if any issue were to arise, I

will be contacted immediately.

_____ _____

Signature Date

Contact Phone Number _____