PINNACLE
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

PATIENT'S FULL NAME _____

PREFERED NAME / NICKNAME _____ MALE _____ FEMALE _____

BIRTHDATE _____ AGE _____ SOCIAL SECURITY (LAST 4 DIGITS) #XXX-XX-_____

STREET ADDRESS _____ZIP CODE_____

HOME PHONE _____WORK PHONE _____ CELL _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE OR VOICE MAIL? YES ____ NO _____

E-MAIL ADDRESS _____ MARITAL STATUS _____

EMPLOYER _____ EMPLOYER'S PHONE #_____

EMERGENCY CONTACT NAME _____RELATIONSHIP_____ PHONE _____

RESPONSIBLE PARTY (if other than patient) _____

NAME OF ATTORNEY INVOLVED (if applicable) _____ PHONE _____

REFERRING MD _____ N/A (check) _____

FAMILY or PRIMARY MD_____ N/A (check) _____

HOW DID YOU HEAR ABOUT US? (CHECK ONE) _____ PHYSICIAN _____ WEBSITE

_____ J-TOWN MAGAZINE _____ PREVIOUS PATIENT (NAME OF PATIENT: _____)

CONSENT OF TREATMENT

I hereby authorize Pinnacle Physical Therapy, through its appropriate personnel, to evaluate and provide any and all treatment to the patient named above, to the extent considered safe, necessary and proper.

X_____ (INITIAL HERE)

AUTHORIZATION TO RELEASE INFORMATION

I further authorize the release of any medical information necessary to process my insurance and I hereby assign all medical benefits to include major medical benefits to which I am entitled to Pinnacle Physical Therapy.

X_____ (INIITIAL HERE)

SIGNATURE _____ DATE _____

PINNACLE
PHYSICAL THERAPY

PATIENT NAME: _____ DATE: _____

History and Physical Condition Information

Have you had any of the following, related to your CURRENT condition?

MRI / Arthrogram	yes no	When? _____	Where? _____
X-rays	yes no	When? _____	Where? _____
Surgery	yes no	When? _____	Where? _____
Physical Therapy	yes no	When? _____	Where? _____
Chiropractic Treatment	yes no	When? _____	Where? _____

Other treatments/dates: _____

List (or provide list) of all medications you are currently taking: _____

_____

Do you have a history of any of the following (Please circle YES or NO):

High Blood Pressure	yes no	Allergic to latex or adhesives	yes no
Heart Disease	yes no	Hernia	yes no
Heart Attack	yes no	Seizures	yes no
Pace Maker	yes no	Metal Implants	yes no
Diabetes	yes no	Dizzy Spells	yes no
Headaches	yes no	Balance Problems	yes no
Kidney Problems	yes no	Vision/Hearing Problems	yes no
Anxiety	yes no	Cancer	yes no
Depression	yes no	Osteoporosis/Osteopenia	yes no
Mental Illness	yes no	Alzheimer's/Dementia	yes no
Stroke	yes no	Genetic Disorders	yes no
Sensitive to heat / ice	yes no	Learning Disabilities	yes no
Sleep Disorders	yes no	Malaise/Lethargy	yes no

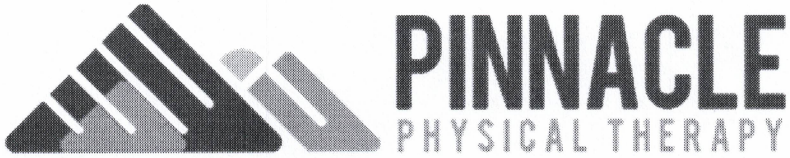
Other Medical Conditions: _____

If you marked "yes" to any of the above, please explain _____

_____

_____

_____



9204 Taylorsville Rd
Suite 101
Louisville, KY 40299

Consent statement

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Pinnacle Physical Therapy, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Privacy Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Pinnacle Physical Therapy at (502) 499-5959 and requesting a revised Notice. We will also post any revised notice at Pinnacle Physical Therapy. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

PLEASE LIST PERSON/PERSONS YOU WISH US TO SHARE YOUR HEALTH INFORMATION WITH:

_____

_____

I have read the privacy policy as required by the HIPPA Privacy Rule.

Signed_____

Date:_____