in Physical Therapy

Patient Registration Form

Today's Date _____/_____/_____
Last Name_____ First_____ Middle_____
Date of Birth_____/_____/_____ Age:_____
Gender: M F Social Status: Single____ Married____ Live with domestic partner____ Live alone____

Contact Information: (please indicate preferred mode)
Phone: Mobile:_____Home:_____Work:_____
Email: _____

Home Address: _____
City:_____ State: _____ Zip Code: _____
Employer:_____Occupation:_____
Employer's address:_____
Emergency Contact --_____Phone_____Relation to patient_____

Briefly describe the reason for your visit today (diagnosis, body part, or physical complaint):
_____
_____
Referring practitioner:_____Location:_____Phone number:_____
Primary doctor:_____Location:_____Phone number:_____
Date of Injury or accident:_____ Did this injury occur at work? Yes No
Did this injury occur as the result of a motor vehicle collision? Yes No

Have you received **any** other Physical Therapy this year ***OR*** have you been previously treated for this injury?
Yes No

If yes, please list here (attach separate sheet if necessary):

Please list any other practitioner you are seeing and how long you've seen them for this injury:

Is there an attorney or pending litigation involved in this case? Yes No

For your first visit you should bring:
Photo ID
Insurance Card
A referral from your doctor if you have one
Copay if you have one
Completed registration forms
You will be most comfortable if you wear **clothing appropriate for assessing your area of injury**. Please bring shorts for lower extremity and spine evaluation and a tank top or sport top for upper body evaluation.

*****You are responsible for verifying your benefits and insurance requirements prior to your first visit. Please fill out these forms in full and bring them with you to your first appointment. Thank you.**

in Physical Therapy

Please fill out in full. Many insurances have changed or are in the process of changing requirements and coverage for physical therapy. You are responsible for understanding your benefits prior to your first visit.

Private Primary Insurance Information

Insurance Company_____ Phone #:_____
Insurance billing address: _____
Subscriber (if you are the subscriber note 'self'): _____D.O.B.:_____
Policy Member ID #: _____Policy Group #:_____
Do you have a co-pay? Yes No How much is your co-pay? _____
Do you have a deductible? Yes No How much is your deductible? _____ How much of your deductible have you met?_____ Does your insurance require a prescription, referral, or preauthorization? _____

Secondary Insurance

Company_____ Phone #_____
Billing address: _____
Subscriber_____ subscriber's D.O.B._____
Subscriber's employer_____ subscriber's phone#_____
Policy member ID_____ Policy Group#_____

L&I/Worker's Comp

Department of L&I: yes no Workers Comp/Self Insured: yes no Date of Injury:_____
Employer (at time of injury):_____
W/C Insurance name _____ Phone number _____
Name of Claim Manager/Adjustor: _____phone #_____
Billing Address: _____
CLAIM NUMBER:_____ Is your claim open? yes no Have you had prior Physical Therapy related to this claim? yes no If yes, now many visits have you had? _____Where_____

Auto Accident PIP

PIP Insurance Co (Auto):_____ **CLAIM NUMBER:**_____
Address _____
_____
Claim Adjuster's name_____ phone number _____
Date Claim Opened _____ Is this claim still open? yes / no
Policy Holder (If self please write self): _____Relationship to Policy Holder: _____
Policy Holder's Address: _____
City:_____ State:_____
Policy Holder's Phone: _____ Policy Holder's Date of Birth: _____

ASSIGNMENT OF BENEFITS

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance and hereby authorize you to evaluate & treat me (or my dependent) & I assign directly to In Physical Therapy P.S., Inc. all medical benefits, if any, for services rendered. I authorize the release of all information necessary to secure payment of benefits. I authorize the release of medical and billing information to my referring physician or insurance company if requested.

_____
SIGNATURE OF INSURED/GUARDIAN **DATE**

Billing Policy

In Physical Therapy provides medical insurance billing through a contacted billing service. There are a number of different insurances often with significant variations in coverage. It is recommended that you verify your insurance benefits before your first visit to understand your coverage and personal financial responsibility for the cost of services.

You will want to know the following:

1. What is your out patient physical therapy benefit (visit or dollar amount, combined services restriction).
2. Do you have a maximum coverage amount per year or lifetime for any given condition? If yes, what is the dollar amount _____ and visit amount _____
3. Do you have a deductible? Yes/no If yes, what amount?_____ Have you satisfied any of this deductible to date? Yes/no Amount already met _____
4. Is In Physical Therapy a provider with your insurance? Yes/no
5. Do you need a **prescription, referral, or pre-authorization** for physical therapy services? Yes/no

****While your insurance company may not require a referral or prescription, it is recommended that you have one on file, as many insurers are requiring proof of **medical necessity** for coverage.*

Please read carefully and sign below

In Physical Therapy P.S., Inc. is unable to accept third party payment for accidents, but will bill PIP. It is the patient's responsibility to cover residual costs not covered and deemed allowable by insurance contract. Uninsured patients are eligible for payment at time of service discount.

COPAYS ARE DUE AT THE TIME OF SERVICE
Payment may be made in cash or check. If you pay cash please bring exact amount as no extra cash is kept on the premises. A returned check fee of $25 will apply. In Physical Therapy is not able to accept credit card payments at this time.

Late Cancellation/No Show Policy:
A $130 late cancellation or no show fee will be charged to any individual canceling with less than 24 hours advance notice. This fee is not payable by insurance.

I verify that I have read the above and am responsible for verifying my own insurance benefits. I understand that In Physical Therapy P.S., Inc. will bill my insurance through a billing service but that I am personally responsible for any copays, deductibles, and balances incurred. I understand that my insurance may not guarantee coverage for services even if prescribed by a physician and listed as a covered medical expense on my insurance plan. If my insurance company denies claims or my claims go into medical review I understand that I am financially responsible for all incurred expenses.

Patient Name _____

Guardian _____ as _____

Signature _____Today's date_____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by In Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of In Physical Therapy.

I understand that diagnosis or treatment of me by **In Physical Therapy** may be conditioned upon my consent as evidenced by my signature on this document.

I understand and authorize that medical records may be kept in paper form or through a protected electronic medical records system compliant with patient privacy practices/HIPAA guidelines.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. In Physical Therapy is not required to agree to the restrictions that I may request. However, if **In Physical Therapy** agrees to a restriction that I request, the restriction is binding on In Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that In Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review In Physical Therapy's Notice of Privacy & Patient Information Practices prior to signing this document.

In Physical Therapy's Notice of Privacy & Patient Information Practices has been made available to me.

The Notice of Privacy & Patient Information Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **In Physical Therapy.**

This Notice of Privacy & Patient Information Practices also describes my rights and the duties of **In Physical Therapy** with respect to my protected health information.

In Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy & Patient Information Practices.

I may obtain a revised notice of privacy & patient information practices by accessing the In Physical Therapy web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____

Name of Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority_____

Notice of Privacy & Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

In Physical Therapy Legal Duty

In Physical Therapy P.S., Inc. (In Physical Therapy) is required by law to protect the privacy of your personal health information, provide this notice about your information practices, and the following information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

In Physical Therapy uses your personal health information primarily for treatment or service, obtaining payment for treatment, conduction internal administrative activities, and evaluating the quality of care that we provide. For example,

In Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefit that could be of interest to you.

In Physical Therapy may also use or disclose your health information without prior authorization for public health purpose, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information required by law.

In any other situation, In Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

In Physical Therapy may change its policy at any time. When changes are made, a new Notice of Privacy & Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Privacy & Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information, other than for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. In Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that In Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address below. You may also send a written complaint to the US Department of Health and Human Services. For further information on In Physical Therapy's health information practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Office: In Physical Therapy P.S., Inc. 3333 Wallingford Ave N, #C-3, Seattle, WA 98103 I (206)930-7882

in Physical Therapy

Medical History

Initials: _____

Current complaint/reason seeking treatment:

_____
_____
_____
_____
_____
_____

What makes your complaint worse?

_____
_____

What makes it better?

_____
_____

On a scale of 0-10, please rate your complaint (0 is no restriction, 10 is fully disabling):
0 1 2 3 4 5 6 7 8 9 10

What are your goals/expectations as a result of physical therapy treatment?:

Handedness: Right | Left
Employment/Profession:_____
Hours spent daily

1. At a computer or desk?
2. Lifting objects heavier than 10#
    a. Number of times/day?
    b. Average weight of objects lifted
3. Driving

Do you normally use a: cane, walker, or other device?
Please list any prescription medications taken:

_____
_____
_____

Non-prescription/over the counter medications:

_____
_____

Rate your overall health:
Excellent Good Fair Poor

Do you exercise outside of your daily activities or participate in any sports or physical activities?
Yes No

Please describe the exercise, sport, or hobby:

_____
_____
_____

On average, how many hours per day do you exercise or do physical activity?_____
How many days per week?_____

Do you now or have you previously used tobacco? Yes no
If yes, please describe:

_____
_____
Year Quit: _____

Do you have a history of chemical dependency?
Yes no

Within the past year have you had any of the following tests:

Angiogram	MRI
Arthroscopy	Myelogram
Biopsy	Nerve Conduction
Bone scan	Pulmonary function
CT scan	Cardiac Stress Test
Doppler ultrasound	X-rays
Echocardiogram	Diagnostic ultrasound
EKG (electrocardiogram)	Other
EMG (electromyogram)	

Results of Medical Tests:

_____
_____
_____
_____

Please list prior **trauma**, **surgery**, relevant or other significant **injury** and approximate date:

_____
_____
_____
_____
_____
_____
_____

in Physical Therapy

Medical History

Initials: _____

Please circle if you have had:
Allergies
Arthritis
Bladder problems (including repeated infections, urinary incontinence, leaking)
Blood disorders (including hemophilia/anemia)
Bone/joint infections
Broken bones/fractures
Cancer
Circulation/vascular problems
Depression
Developmental or growth problems
Diabetes or problems with blood sugar
Eating disorder
Fibromyalgia
Head injury
Heart problems
High blood pressure
Infectious diseases (such as tuberculosis, hepatitis, HIV)
Kidney problems
Liver problems
Lung problems (including asthma)
Metal implants
Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)
Osteoporosis
Pacemaker
Seizures/epilepsy
Sensitivity to latex rubber
Skin diseases
Thyroid problems
Ulcers/stomach problems
Other:_____

MEN
Have you ever been diagnosed with prostate disease?
Yes/no

WOMEN
Have you ever been diagnosed with:
Pelvic inflammatory disease
Endometriosis
Trouble with your period
Complicated pregnancy/delivery
Have you had a hysterectomy? Yes / no
Have you had a cesarean delivery? Yes / no
Are you pregnant or do you think you might be pregnant?

Are you seeing anyone else for this diagnosis?
Yes no
if yes, please list:
_____
_____
_____

In the past year have you had?

Bowel problems	Loss of balance/falls
Chest pain	nausea/vomiting
Coordination problems	pain during the night
Chronic cough	sexual dysfunction
Difficulty sleeping	shortness of breath
Dizziness or blackouts	urinary problem
Fever/chills/sweats	vision problems
General malaise	weakness arms/legs
Headaches	weight loss/gain
Hearing problems	loss of appetite
Heart palpitations	Hoarseness

How did you hear about In Physical Therapy?

_____