WASHINGTON PHYSICAL THERAPY AND REHABILITATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____Gender: ___M ___F
*Email: _____ Home Phone #:_____
Address:_____ Mobile Phone #: _____
City/State/Zip: _____ Referring Physician:_____

RESPONSIBLE FOR PAYMENT
(if someone other than self)

Parent/Guardian Name:_____ Relationship to Patient:_____
Date of Birth:_____ Phone Number: _____
Address (if different):_____ Is the patient a student?:_____
City/State/Zip: _____ Employer/Position:_____

METHOD OF PAYMENT

___Self Pay ___Health Insurance ___Auto/PIP Claim #_____ ___L and I Claim #_____

Health Insurance Company: _____ Subscriber Name: _____
Subscriber Number:_____ Phone Number:_____
Group Number: _____ Employer:_____
Address:_____ Date of Birth:_____
City/State/Zip:_____

If auto related accident as reason for physical therapy, please also list auto insurance coverage

Auto (PIP) Insurance Company:_____ Claim Number:_____
Address:_____ Date of Accident:_____
City/State/Zip:_____ Subscriber Name:_____
Phone Number:_____ Date of Birth:_____

REASON FOR PHYSICAL THERAPY

Problem you are seeking treatment for:_____
If caused by accident or injury, what type?: _____Work _____School _____Sports _____Auto _____Home _____Other
Date of injury:_____
If work related, did you fill out an accident report at work? _____Yes _____No Claim #:_____
Has an accident report been filed with another office/hospital? _____Yes _____No Claim #:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____
Phone Number(s):_____

OUR POLICY

We require 24 hours notice of cancellation of appointments. Failure to notify the clinic of cancellation will result in a charge to you of $25, or $15 if less than 24 hours notice is given.

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY

I hereby consent to treatment at Washington Physical Therapy and Rehabilitation (WAPT) as deemed advisable by myself or referring provider. I authorize WAPT to release medical records to my insurance company and/or attorney for payment of services. I authorized my insurance benefits to be paid directly to WAPT. I understand the above policy and agree to be financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement or pending labor or industrial claims. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

*WAPT uses secure HIPAA compliant email. I give WAPT permission to communicate with me via email regarding health information, medical records, offers, and other related correspondence.

Signature (If minor, parent/guardian):_____Date:_____

HEALTH HISTORY

Name:_____
Date of last physical exam:_____

Have you ever had heart trouble or circulatory problems (heart attack, stroke, ECG abnormalities, heart valve problems, heart murmur)?

- ☐ No
- ☐ Yes
  Explain:_____
  _____
  _____
  _____

Have you ever experienced pain or discomfort associated with chest, arms, neck, jaw, upper back, etc.?

- ☐ No
- ☐ Yes
  Explain:_____
  _____
  _____
  _____

Do you have diabetes?

- ☐ No
- ☐ Yes

Are you pregnant?

- ☐ No
- ☐ Yes Due date:_____

Have you ever had or do you currently have borderline or high blood pressure?

- ☐ No
- ☐ Yes If you know your BP, please indicate:_____
  _____

Are you a current smoker or have you smoked in the past?

- ☐ No
- ☐ Yes If yes, please indicate total years, cigarettes per day, or date you quit smoking:_____
  _____
  _____

Have you ever experienced a seizure?

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Has your health care provider ever told you that your cholesterol is too high?

- ☐ No
- ☐ Yes If you know your cholesterol, please indicate:_____
  _____

Do you have any lung conditions or asthma, where you experience shortness of breath with moderate exertion?

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Do you have fainting spells, or experience dizziness?

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Do you have a muscle or joint problem or injury, which may require staff assistance in formulating safe exercise prescription:

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Are you currently under the care of a physician or are you currently taking any medications?

- ☐ No
- ☐ Yes Explain/List:_____
  _____
  _____

Did either of your natural grandparents, parents, aunts, uncles, or siblings experience a heart attack, stroke, diabetes, high blood pressure, high cholesterol, or cancer before the age of 60?

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Are you aware of any condition not mentioned above that may affect your ability to exercise?

- ☐ No
- ☐ Yes Explain:_____
  _____
  _____

Are you physically active?

- ☐ No
- ☐ Yes List activities:_____
  _____
  _____

WASHINGTON PHYSICAL THERAPY AND REHABILITATION, LLC

It is the patient's responsibility to know their own outpatient physical therapy health insurance benefits. Each patient must call their customer service number, typically found on your health insurance card, for explanation of physical therapy reimbursement benefits. Also, refer to your plan booklet.

Some of the benefits to consider:

- Is Washington Physical Therapy and Rehabilitation (WAPT) credentialed with your insurance company?
- What is your yearly deductible? How much are you required, by the plan you are on, to pay each year before your benefits can start? This deductible may include all health care.
- Do you have a copayment? This is the set fee you are required by your plan to pay at each visit.
- LIMITATIONS
    - How many visits does your plan give you per year?
    - Is there a maximum amount per year that your plan pays?
- REFERRAL
    - Is a physician referral required? Does it need to be from your primary care provider (PCP)? Or can it be from a specialist?
      How long is the referral valid?
- PRE-AUTHORIZATION
    - Do you need preauthorization prior to being seen?
    - Is there a set number of visits before preauthorization is needed to continue?
- Are there services and products not covered by your plan?
- Percent paid: many plans only pay a percentage of the total amount per visit. The remaining percentage is your coinsurance and is your responsibility.
- Coinsurance: If you have health insurance, you most likely will have a coinsurance amount due to WAPT. This is what you owe after your plan has paid their covered percentage.
- Are there any other benefits/limitations to know about? All insurance companies have various and numerous plans, and each one is different. They are all continually changing, so stay updated with your plan.

The patient is responsible for all charges for services rendered regardless of insurance reimbursement. As a courtesy to you, we bill your insurance company. We are not responsible for their determination of payment. That is between you and your insurance company.

The following therapists are practicing at WAPT:
Michael D. Lewis, M.S, P.T.
Cindy Zech, P.T, M.Ed

The undersigned states that he/she has read and understands the terms and conditions relating to their responsibilities associated with their insurance reimbursement benefits for physical therapy, and that they are personally responsible for the payment for services rendered at Washington Physical Therapy and Rehabilitation.

Patient Signature:_____Date:_____

WASHINGTON PHYSICAL THERAPY AND REHABILITATION, LLC

Welcome to Washington Physical Therapy and Rehabilitation, herein referred to as WAPT. As a patient, you will receive evaluation and treatment from a licensed physical therapist, or by a physical therapist assistant under their supervision. You have access to the facilities' amenities as approved by your therapist so long as you are being treated as a current and active patient.

We request that you schedule appointments and honor those scheduled times. If you need to cancel or reschedule an appointment, please call 24 hours in advance. Failure to notify the clinic of cancellation within this time, or being a no show for your appointment, will result in a charge to you of $25.00. Notice of cancellation less than 24 hours may result in a $15 late cancellation fee. If there are two no shows in a row, any future appointments that have been made will be canceled and you will need to reschedule.

You, the patient, are ultimately responsible for all charges associated with your care regardless of insurance coverage. ***It is your responsibility to be informed of your insurance plan's benefits.***

Co-payments are to be paid at the time of each visit, **by cash, check, Visa or MasterCard**. There will be a $20.00 NSF fee charge for all checks returned to WAPT.

As a courtesy to you, we will bill your insurance company. We are not responsible for their determination of payment. That is between you and your insurance company. The billing department will assess a rebilling service fee of $5.00 each billing period on any unpaid balance after 60 days. All accounts not paid in a timely manner will be sent to collections. To prevent this, arrangements for payments will need to be made.

If the patient is a minor (18 years or younger) the parent or guardian must sign all paperwork, and is responsible for any payment due, co-pays at the time of service, insurance information, and required referrals.

I, the undersigned, have read and agree to this financial policy. I hereby consent to the performance of physical therapy services provided by WAPT.

I, the undersigned, authorize the provider and WAPT to release information and medical records to any person or incorporation that is or may be liable under a contract to the provider, WAPT, or to the patient or to a family member or employer of the patient for all or part of the provider's or WAPT's charges. Persons or entities that are hereby authorized to receive the information include, without limitation, hospital or medical service companies, insurance companies, workman's compensation carriers, welfare funds, my attorney, and/or the patient's employer.

Patient Signature_____ Date_____

Washington Physical Therapy and Rehabilitation, LLC
Informed Consent and Waiver of Liability

Thank you for choosing to use the facilities, services, or programs of Washington Physical Therapy and Rehabilitation (hereinafter referred to as WAPT). We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

Name:_____

I declare that I intend to use some or all of the activities, facilities, programs, and services offered by WAPT, and I understand that each person (myself included) has a different capacity for participating in such activities, facilities, programs, physical therapy, rehabilitation, and other services. I assume responsibility, during and after my participation for my choices to use or apply, at my own risk, any portion of the information, instruction, or services that I receive.

I understand that there exists the remote possibility of adverse changes occurring during exercise including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and very rare instances of heart attack, stroke, or even death. I further understand that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. I have been told that every effort will be made to minimize these occurrences by proper staff assessments of my condition, and by my own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke, or even death, but knowing these risks, it is my desire to participate as herein indicated.

In the event of physical injury resulting from the evaluation procedures, equipment usage, or equipment testing, no medical treatment or monetary compensation will be provided by the institute. I must look to my own health insurance policies.

I understand that WAPT services are supervised by state licensed physical therapists. I further understand that other activities, programs, and services offered by WAPT are sometimes conducted by personnel who may not be licensed, certified, or registered instructors or professionals. I accept the fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered and herein employed to provide such professional services.

Programs related to Athletic Performance and Fitness: I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions and personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use fitness equipment, and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program's instruction I will likely improve me exercise capacity and fitness level after a period of six weeks to six months.

I have been informed that the information obtained will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I do however, agree to the use of any information that is not personally identifiable with me for research and statistical purposed so long as the same does not identify me or provide facts that could lead to my identification. I also agree to the use of any information for consultation with other health/fitness professional including my doctor. Any other information obtained, however, will be used by the program staff while prescribing exercise for me and evaluating my progress in the program.

I further understand that there are also other remote risks that may be associated with exercise. Even though a complete accounting of all these remote risks has not been provided to me, it is still my desire to participate.

It is expressly agreed that all the use of WAPT facilities and any transportation provided by WAPT should be undertaken by a client or guest at his/her sole risk, and the Institute shall not be liable for any injuries or any damage to any member or guest, or the property of any client or guest, or be subject to any claim demand, injury or damages whatsoever, including, without any limitations those damages resulting from acts of active or passive negligence on the part of WAPT, its officers or agents. The client, for himself/herself and on behalf of his/her executors, administrators, heirs, assigns and successors, does hereby expressly forever release and discharge WAPT, its owners, officers, employees, agents, assigns and successors from all such claims, demands, injuries, damages, actions or causes of action. WAPT shall not be responsible or liable to client or their guests for articles damaged, lost or stolen on or about WAPT, or in lockers, or for loss or damages to any property including but not limited to automobiles and the contents thereof.

I expressly consent to the rendition of all services and procedures as explained herein by all program personnel. I acknowledge that WAPT staff is relying on all information provided by me regarding my medical history and condition before allowing me to participate in any evaluation or program. I certify that the information provided to be true and correct.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read.

Signature of Participant_____ Date_____

Signature of Parent/Guardian_____ Date_____

Washington Physical Therapy and Rehabilitation
6725 116th Ave NE Ste 130
Kirkland, WA 98033

NOTICE: Privacy and Security DATE: April 14, 2003
Updated: April 2007

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ASSESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have the important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our office at 425-820-2110.

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ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Privacy Practices for The Health Trust under the Health Insurance Portability and Accountability Ace (HIPAA).

Client/Patient Signature:_____

Date:_____

Client/Patient if unable to sign do to the following reasons:

- The patient refused to sign
- Communication barriers
- Emergency situation:_____
- Other:_____

Authorized Client/Patient Representative Signature:

_____ Relationship (family member):_____

Policy Date: April 1, 2003
Updated: April 2007