Advance Physical Therapy, 15623 – 1st Ave S, Ste C, Burien, WA, 98148

Patient Information: Email Address (for appt reminders): ______________________________

First Name: ____________________ Middle Initial: ____________ Last Name: ____________________

Address: ______________________________ City: ______________ State: ______ Zip Code: __________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________ ☐ Married ☐ Single

SS #: ______________________ Birth date: ________________ Sex: ☐ Female ☐ Male

How did you hear about our clinic? (Circle One): Bing Google Yelp Facebook Friend/Other: ________________

Care Provider Information:

Referring Practitioner: ______________________________ Phone: (   ) ________________

Primary Care Provider: ______________________________ Phone: (   ) ________________

Insurance Information: (please give card(s) to receptionist) Are you covered under an Employer or Union policy? Yes / No

Primary Insurance: __________________________ Subscriber: ________________ Birth date: __________

ID#: __________________________________ Group/Policy #: ____________________________

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other/Domestic Partner

Employer: ____________________________________ Work Phone: (   ) ______________ Ext: ______

Secondary Insurance: __________________________ Subscriber: ________________ Birth date: __________

ID#: __________________________________ Group/Policy #: ____________________________

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other/Domestic Partner

Employer: ____________________________________ Work Phone: (   ) ______________ Ext: ______

Auto / Work Injury Claim: *(please provide your health insurance information in case of exhausted benefits or denial)*

Insurance Name: ☐ Auto: ________________________ ☐ Labor & Industries: ______________________

Employer: ____________________________ Address: __________________________

Work Phone: (   ) ____________

Adjuster/Claim Manager: __________________________ Phone: (   ) ________________ Ext: _______

Address: __________________________ City: ________________ State: ______ Zip Code: _________

Claim #: __________________________ **Accident/Injury Date:** ______________ Cause: ____________

Attorney Information:

Name: ______________________ Law Firm: ______________________ Phone: (   ) ______________

Address: __________________________ City: ____________________ State: ______ Zip Code: __________

In Case of an Emergency:

Name of local friend or relative (not living at the same address) ________________________________

Relationship to Patient: ______________________ Phone (   ) ________________________

Authorization for release of information. Assignment of insurance benefits and promise of payment:

Authorization is hereby granted to release to the ________________ Insurance Company such information as may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by my insurance. I hereby instruct and direct my insurance company to pay by check made out to the above clinic and mailed to the above clinic address. If my current policy prohibits direct payment to the above clinic, I hereby also instruct and direct you to make out the check to me and mail to the above clinic. I also authorize the clinic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: ________________________________ Date: ________________________

Advance Physical Therapy
206-444-6320

Consent to Treat

This is an agreement between Advance Physical Therapy, a Washington Professional Corporation, as creditor, and the Patient/Debtor named on this form.
In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Advance Physical Therapy.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Re-billing Fee: A re-billing fee of $5 will be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. We accept cash, checks and most major credit cards.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Missed appointment fee: We will write off the first missed appointment fee. After the first missed appointment all subsequent missed appointments and/or cancels with less than 24 hours notice, will be charged a **$75.00 fee**, this fee cannot be charged to insurance carriers. Patients with two missed appointments will be discharged. Patients that wish to continue physical therapy after being discharged due to missed appointments will have to pay all of their missed appointment fees up front.

Reminder calls about appointments: You are responsible for remembering your appointments. If you give us a valid email our computer system will email you a reminder before your appointments. We will not call you to remind you about your appointments. If you miss an appointment because you did not get a reminder, you are responsible for the missed appointment fee, since you are ultimately responsible for your appointments.

Required payments: Any co-payments required by an insurance company must be paid at the time of service.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Simple Agreement Form: Patient authorizes the Doctor/Clinic to deposit checks received on the Patient's account when made out to the patient.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in King County, Washington. We may also record a lien with the King County District Court in order to collect on any debts.

Consent to Treat: You give consent to Advance Physical Therapy to evaluate and treat your medical condition.

The Financial Policy continues on the back side of this page.

Patient's name: ____

Responsible party
(if not the patient): ____

Signature: ______________________________________ Date: ______________________

Co-Signature: ____________________________________ Date: ______________________

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Medicare Patients: Medicare will only pay for the services that it determined to be reasonable and necessary under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service although it would otherwise be covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. My physician has authorized and ordered physical therapy services and has determined it be reasonable and necessary. In spite of this, I understand there is a possibility Medicare may still deny payment. I agree to be personally and fully responsible for payment should the services be denied.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied or closed during the course of treatment, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. In addition we may require a lein. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Release of Information: I hereby authorize Advance Physical Therapy & Sports Rehabilitation, INC to release any information required to process this claim. I also authorize release of information to my referring health care practitioner.

Notice of Privacy Practices

Effective: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

When you receive care from us, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information are included:

Treatment: We keep records of care and services provided you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services provided to you to claim and obtain payment from your insurance company or Medicare.

Health Care Operations: We use your health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties, and to make plans to better serve our patients.

To use your health information for other than the above uses requires your signed authorization.

There are limited situations when we are permitted or required to disclose health information without your signed authorizations. These situations include:

- For public health purposes such as reporting communicable diseases, work-related illness, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drug problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- To reduce and prevent a serious threat to public health and safety.
- For other limited situations, see the full copy of our Notice of Privacy Practices.

We are required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make new privacy practices effective with all the information we maintain. You may request a copy of any notice from our Privacy Officer.

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restrictions.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances we may deny you access to some portion of your health information and you may request a review of the denial.
- Request amendments or additions to your health record.
- Request an accounting of certain disclosures of your health information made by us.

All above requests must be made in writing through our Privacy Officer.

This notice summarizes our Privacy Practices. If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information: Contact your Privacy Officer: Brad Bentley, DPT.

We will investigate all complaints and will not retaliate against you for filling a complaint. You may also file a written complain with the Office of Civil Rights of the U.S. Department of Health and Human Services.

We are required by law to have you sign an ***Acknowledgement of Receipt of Notice of Privacy Practices.*** We would appreciate your cooperation by obtaining a copy from the receptionist.

Patient Name: ____

I hereby acknowledge that I have received a copy of Advance Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_______________________________________ ____________________

Patient Signature Date

_______________________________________ ____________________

Representative Signature (if applicable) Relationship to Patient

Advance Physical Therapy

206-444-6320

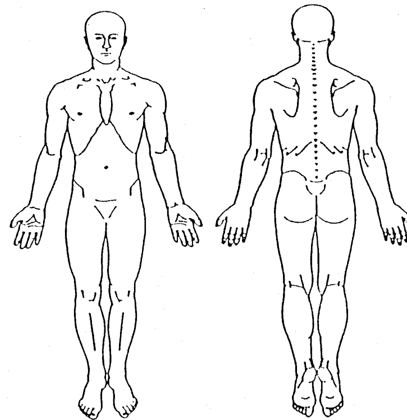
Name: ___________________________
Date: ______________________________

Health History

Primary Complaint ____
Injury caused from: ____
Secondary Complaint ____
Injury caused from: ____

Have you had x-rays, MRI or other tests? ☐ Yes ☐ No
Findings? ____________________________________

Shade areas of symptoms:



Describe your symptoms. Please check all that apply:

☐ Dull ache	☐ Burning	☐ Heavy
☐ Deep ache	☐ Throbbing	☐ Twinge
☐ Stabbing	☐ Squeezing	☐ Cramp
☐ Nagging	☐ Sharp	☐ Sore
☐ Numbness	☐ Tingling	

Any others that may be relevant:

____

Rate your pain: *No pain* 0 1 2 3 4 5 6 7 8 9 10 *Worst possible pain*

Date symptoms started ____
What makes your pain better? ____
What makes your pain worse? ____

Do you feel you are getting ☐ better? ☐ worse? ☐ staying the same?

Rate your functional ability (%):
Completely incapacitated 0 10 20 30 40 50 60 70 80 90 100 *Prior level of function*

What are your personal goals for physical therapy? (please check all that apply)

☐ Decrease pain	☐ Return to sports, hobbies, recreation
☐ Improve motion	☐ Learn proper body mechanics
☐ Increase strength	☐ Improve posture
☐ Return to work	☐ Other (specify) ______________________________
☐ Improve sleep	______________________________

Please list ALL medications you are taking (prescribed, over-the-counter, supplements, etc.).

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Have you had physical therapy this year? If yes what for: __________________________________

____

Health History Page 2 Name: ___________________________________

How often do you exercise?

- ☐ Daily
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ Less than once per week

What exercise do you do?

☐ Walk	☐ Gym exercise
☐ Run/jog	☐ Tennis
☐ Swim	☐ Golf
☐ Biking	☐ Other____________

Do you smoke? ☐ Yes ☐ No Packs per day ______

Age______ Height______ Weight______

Please check all that apply to you:		Comments
Anemia	☐	______________________________
Asthma	☐	______________________________
Cancer	☐	______________________________
Chemical dependency (e.g. alcoholism)	☐	______________________________
Constipation/diarrhea	☐	______________________________
Depression	☐	______________________________
Diabetes	☐	______________________________
Emphysema	☐	______________________________
Epilepsy	☐	______________________________
Headaches	☐	______________________________
Heart problems	☐	______________________________
Hepatitis	☐	______________________________
High Blood Pressure	☐	______________________________
Insomnia	☐	______________________________
Jaw/Face Pain	☐	______________________________
Kidney disease	☐	______________________________
Loss of bowel/bladder control	☐	______________________________
Multiple Sclerosis	☐	______________________________
Pacemaker	☐	______________________________
Pregnant/possibility of pregnancy	☐	______________________________
Rheumatoid Arthritis	☐	______________________________
Other arthritic problems	☐	______________________________
Stroke	☐	______________________________
Surgery (abdominal, orthopedic, etc.)	☐	______________________________
Thyroid problems	☐	______________________________
Tuberculosis	☐	______________________________
Other	☐	______________________________

Is there anything else you think we should know, but did not ask? ☐ Yes ☐ No
If yes, please specify: ____
____

Patient Signature____**Date**_____________________