SEDRO-WOOLLEY
Physical Therapy

638 Sunset Park Dr. Ste 101
Sedro Woolley, WA 98284
Phone: (360) 856-4200
Fax: (360) 85604220
Website: www.swpt1.com

TODAY'S DATE_____

Last Name_____ First Name_____ M.I._____

Street Address _____ City_____ State_____ Zip _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( ) _____

Emergency Contact: Name/Relation_____ Phone Number( )_____

Social Security Number_____ - ____ - _____ Date of Birth _____/_____/_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

Check one:
☐ Smoker ☐ Non smoker

Referring Physician_____ Date of your NEXT appointment _____
Primary Care Physician_____ Surgeon (if applicable)_____
Date of Surgery_____
Date of Injury_____

Are you here because of an **auto accident**? ☐ Yes ☐ No Auto Claim #_____
Do you have an attorney? ☐ Yes ☐ No Attorney's Name _____Attorney's Phone#_____

Work Status: ☐ Fulltime ☐Part-time ☐ Retired ☐ Regular duty ☐ Light-duty

Have you had any diagnostic tests? ☐ Yes ☐ No When _____ Where _____

Please circle all that apply: X-Ray CT Scan MRI Nerve Conduction Other_____

Have you received any Physical, Occupational or Speech Therapy services since January 1, 2015? ☐ Yes ☐ No

If yes, how many visits occurred and where were the services received? _____

For Office Use Only: Required PQRS/Functional Outcome Measures

☐ BMI: Height_____ Weight_____

☐ Pain: Pain scale completed

☐ Functional Outcome Test_____

☐ Medications reported and verified with patient

☐ Fall Risk questionnaire completed: If answered yes, then check Blood Pressure_____/_____

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Patient Name:_____Date:_____

Date of surgery/injury/problem began: (Medicare requires **specific date**)_____

Treatment location (back, neck, extremity)_____

Describe briefly how you were injured_____

_____

Medical History

- ☐ No known significant medical history to affect treatment
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Cardiovascular disease_____
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Allergies(specify)_____
- ☐ History of Cancer (type)_____
- ☐ Current infection
- ☐ Fracture or suspected fracture
- ☐ Other_____

Prior surgeries/date_____

_____

Are there any other medical issues we should be aware of?

☐ Yes _____

☐ No known significant past medical history to affect treatment

Do you have a pacemaker? ☐ YES ☐ NO

Please provide the receptionist with your insurance card and photo ID so that we may copy it for billing accuracy.

How did you hear about Sedro Woolley PT?

My Doctor ☐Family Member _____ ☐Friend_____ ☐Yellow Pages ☐Internet ☐Other _____

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Medicare Supplemental Intake Paperwork

We are required by Medicare to document your prior and current level of function. We have developed this supplemental intake paperwork so that we may correctly document the information required by Medicare.

- Please **only** check the box if you are CURRENTLY **limited** in an activity you used to be able to perform before the onset of your symptoms.
- Do **NOT** check the box if you are **ABLE** to perform the activity.

Self Care

As a result of your current pain/injury, are you having difficulty with the following? If you check the box "yes" please briefly describe the difficulty and feel free to comment below.

☐ Driving _____

☐ Sleeping_____

☐ Housekeeping Tasks_____

☐ Food Preparation_____

☐ Performing care giving tasks_____

☐ Performing hygiene tasks (i.e bathing, putting on deodorant, brushing hair)_____

Comments:

Changing & Maintaining Body Position

As a result of your current pain/injury, are you having difficulty or pain with the following? If you check the box "yes" please describe difficulty and feel free to comment below.

☐ Maintaining a body position _____
(i.e. sitting/lying/standing in one position)

☐ Changing positions_____
(i.e. getting up from chair, out of bed)

Comments:

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Mobility: Walking & Moving Around

As a result of your current pain/injury, are you having difficulty with the following? If you check the box "yes" please describe difficulty and feel free to comment below.

☐ Walking between the rooms of your home_____

☐ Walking in the community (parking lots, sidewalks, stores)_____

☐ Walking on uneven terrain (grass, inclines/declines)_____

☐ Going up/down stairs and curbs_____

☐ Sports activities (running, jumping, swimming)_____

Are you currently using an assistive device? (cane, walker, crutches...)

☐ Yes ☐ No ☐ N/A

Prior to the onset of your current symptoms were you using an assistive device?

☐ Yes ☐ No ☐ N/A

Comments:

Carrying, Moving & Handling Objects

As a result of your current pain/injury, are you having difficulty with the following? If you check the box "yes" please describe difficulty and feel free to comment below.

☐ Using your hand or arm normally (reaching, lifting, carrying)_____

☐ Fine motor tasks (buttons, manipulating small items)_____

☐ Perform the duties of your occupation/job_____

☐ Recreation/Hobbies (gardening, wood shop, working on car)_____

Comments:

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Pain Assessment: Please rate the pain for which you are currently seeking treatment.

Pain Level *at its WORST*:

None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Pain Level *right NOW*:

None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Pain Level *at BEST*:

None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

My pain worsens with:

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Going up stairs
- ☐ Going down stairs
- ☐ Sit to stand
- ☐ Bending
- ☐ Voiding
- ☐ Coughing/Sneezing
- ☐ Other_____

My pain is alleviated with:

- ☐ Medication
- ☐ Heat
- ☐ Ice
- ☐ Exercise
- ☐ Stretching
- ☐ Chiropractic
- ☐ Massage Therapy
- ☐ Other_____

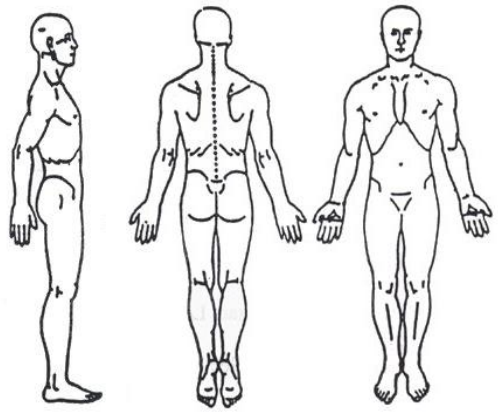
_____

Please choose only the ***ONE* option that best describes your pain:**

- ☐ Burning
- ☐ Sharp
- ☐ Dull/achy
- ☐ Throbbing
- ☐ Shooting
- ☐ Numb/Tingling
- ☐ Constant
- ☐ Intermittent
- ☐ Worse in AM
- ☐ Worse in PM
- ☐ Worse at night

Treatment side: ☐ Left ☐ Right ☐ Both

Indicate on the diagram below, the location of your pain



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Fall Risk Assessment:

Have you had 2+ falls within the last 12 months? Yes☐ No☐
Were you injured resulting from a fall in the last 12 months? Yes ☐ No☐
If YES, answer the following questions. ***If you answered NO, SKIP THIS PAGE***

Describe the circumstances of your 2 most recent falls (time of day, location of fall etc...)
1._____
2. _____

FALL RISK QUESTIONNAIRE

On a scale of 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you could do the following activities without falling?

Take a bath or shower:
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Reach into cabinets or closets:
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Walk around the house
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Prepare meals not requiring carrying heavy or hot objects
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Get in and out of bed
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Answer the door or telephone
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Get in and out of a chair
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Getting dressed and undressed
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Personal grooming (i.e. washing your face)
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

Getting on and off of the toilet
Very confident: 1 2 3 4 5 6 7 8 9 10: Not at all confident

TOTAL: _____

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Medicare requires us to obtain a detailed list of your current medications. List all medications you are currently taking (including vitamins/herbs and over the counter medicines) in the space below. *You may provide us with your own handwritten or typed list if you prefer as long as you have dosage, frequency etc...*

Medication Name	**Used for** (pain, blood pressure etc.)	**Dosage**	**Frequency**	**Method of Administration:** *(oral, sublingual, topical, injection)*

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CANCELLATION & NO SHOW POLICIES

CANCELLATION POLICY

Cancellations or changes to scheduled appointments **must be made 24 hours in advance** of your scheduled appointment in order for us to provide the highest quality of care for all of our patients.

We understand that things come up (specifically illness, transportation issues, hazardous conditions, or family emergencies), and we can accommodate unplanned emergency cancellations without 24 hours notice in these circumstances. However, if you cancel more than three (3) appointments within a 4-week time period, regardless of circumstances, a $15 fee will be issued. This fee is due at the time of your next appointment in order to be seen by the therapist. This **fee is not covered by your insurance** and it is your responsibility, no matter what type of insurance you have. By signing this form, you are agreeing to this policy.

NO-SHOW POLICY

A missed appointment impacts at least three people: 1. You, the patient, who misses a needed therapy session; 2. Another patient who could have been scheduled at your time; and 3. The therapist/owner who must staff the clinic whether you show up or not.

If you fail to attend a scheduled appointment without notification, a $15 fee will be issued. This fee is due at the time of your next appointment in order to be seen by the therapist. This **fee is not covered by your insurance** and it is your responsibility, no matter what type of insurance you have. By signing this form, you are agreeing to this policy.

TIMELINESS

We make every effort to start your appointment at the scheduled time. Occasionally, we are delayed by an unexpected event with another patient. If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule. The therapist can choose to proceed with treatment, but your appointment will end at its scheduled time.

PATIENT CONSENT TO CANCELLATION & NO SHOW POLICY

- I acknowledge that I have read and understand and agree to the cancellation, no-show and timeliness policies as stated above.
- I understand that I am financially responsible for all charges related to cancelling or no-showing, and that **these charges are not covered by my insurance**, no matter what type of insurance I have.
- I understand that the parent/guardian of a minor will be responsible for payment.

Patient Signature_____ Date_____

(Parent or guardian's signature if patient is under the age of 18)

Witness Signature _____Date_____

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FINANCIAL POLICY AND CONSENT & RELEASE

FINANCIAL POLICIES

We will gladly bill many insurance companies. We will do our best to verify that we can bill your insurance company. We will also make every attempt to obtain accurate information regarding your physical therapy benefits. If payment is denied by your insurance company after you have received treatment, you are responsible for the balance on your account. If we find that your insurance company does not cover physical therapy treatment, we will do our best to work out a solution for you so that you may receive the treatment needed.

Many insurance plans will require a co-payment. You are responsible for making co-pays at the time of your visit.

Payment must be made either at the time services are rendered or upon the receipt of your bill in the mail unless you contact us to make other arrangements. We are very willing to work out a payment schedule with you if your financial situation will not let you pay the full balance. If you do not contact us and your account is excessively past due, it will be turned over to collections.

If you have any questions about financial policies or need assistance with your bill or insurance, please call (360) 856-4200.

PATIENT CONSENT AND RELEASE

- I understand that Sedro Woolley Physical Therapy is not responsible for any personal belongings that I bring to the clinic.
- I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement or pending claims.
- I understand that the parent/guardian of a minor will be responsible for payment.
- I authorize Sedro Woolley Physical Therapy to release any necessary information requested by my insurance carrier, my employer's medical department, medical consultants, or my physician. I authorize Sedro Woolley Physical Therapy to obtain any diagnostic test results, including but not limited to X-ray, CT scan, and MRI imaging reports, pertaining to the current medical condition.
- I authorize payment directly to Sedro Woolley Physical Therapy for any benefits available under my insurance plan.
- I agree to pay co-payments (if applicable) for each visit at the time of service.
- I acknowledge that I have read and understand the financial policies as stated above.
- I hereby authorize and consent to treatment by Sedro Woolley Physical Therapy personnel.

Patient Signature_____ Date_____

(Parent or guardian's signature if patient is under the age of 18)

Please advise us immediately of any changes that may affect your billing

(change in insurance policy or claim number, address etc…)

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ACKNOWLEDGEMENT of PRIVACY PRACTICES

I hereby acknowledge that I have received the Sedro Woolley Physical Therapy "Notice of Privacy Practices."

Patient Signature_____ Date_____
(Parent or guardian's signature if patient is under the age of 18, or Personal Representative Signature)

Witness Signature _____Date_____

An updated copy of this Notice of Privacy Practices is located at
www.SWPT1.com
and is also available at the scheduling desk.