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

Referring Physician_____ Date of your NEXT doctor appointment_____
Primary Care Physician_____ Surgeon (if applicable)_____
Date of Surgery_____
DATE OF YOUR INJURY: _____
Have you had any diagnostic tests? ☐ Yes ☐ No If yes, when and where?_____
Please circle all that apply: X-Ray CT Scan MRI Nerve Conduction Other_____

Have you been treated for this condition by another provider? ☐Y ☐N Provider Name: _____
Check all that apply for *this* condition: ☐Injection(s) ☐Chiropractic ☐Massage ☐Acupuncture
☐Other/Procedures (please specify): _____

Are you here because of a **WORK-RELATED INJURY**? ☐ Yes ☐ No Claim #_____Claim is ☐open ☐closed
Employer_____ Employer's Address _____
Employer's Ph#_____ Your occupation?_____
Work Status: ☐ Fulltime ☐Part-time ☐ Unemployed ☐ Retired
☐ Regular duty ☐ Light-duty ☐ On time-loss ☐ Student

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#_____

Insurance Company_____ Subscriber_____
Have you received any Physical, Occupational or Speech Therapy services since January 1, 2016? ☐ Yes ☐ No
If yes, how many visits occurred and where were the services received? _____

How did you hear about Sedro Woolley PT?

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

For Office Use Only:

If Medicaid/Evicore or L&I, Functional Questionnaire _____
Height _____ Weight _____ BMI _____

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

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Patient Name _____ Date _____

Date of surgery/pain/problem began (be as specific as possible) _____
Describe briefly how you were injured _____
Treatment side: ☐Left ☐Right ☐Both ☐N/A Treatment location (back, neck, etc)_____

Cause for Therapy (choose one):
☐Auto Accident
☐Fall
☐Employment Injury
☐Sports Injury
☐Surgery
☐None of these

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_____

Please circle **ONLY ONE** that **B E S T** describes your pain:

Burning sharp dull achy throbbing shooting numb/tingling

constant intermittent worse in AM worse in PM

Medical Conditions:
List all medications that you are taking: (you may provide a list for us to copy if you choose)
Prescriptions_____
Over the Counter _____(for)_____
Prior Surgeries/date _____

Check any medical conditions:

☐Diabetes Type 1
☐Diabetes Type 2
☐Arthritis _____
☐Asthma
☐High Blood Pressure
☐Cancer _____
☐Tuberculosis
☐HIV/AIDS
☐Hepatitis (type)_____
☐Allergies

Are there any other medical issues we should be aware of?
☐ Yes _____
☐ No known significant past medical history to affect treatment

Are you pregnant?	**N/A**	**Yes**	**No**
Do you have a pacemaker?		**Yes**	**No**

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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_____

Policy as of January 1, 2014

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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.