Patient Registration

Today's Date________________

Patient Information

First Name______________________________MI____ Last Name______________________________

DOB___/___/______ Social Security Number_____-____-________ ◯ Male ◯ Female

Street Address______________________________________City____________State_____ Zip__________

Email address____

Home Phone(___)________________ Cell Phone (___)______________ Work Phone (___)______________

Contact Preference: ◯ Home phone ◯ Cell phone ◯ Work phone

How would you prefer to receive appointment reminders? ◯ Text message ◯ Voice message ◯ Email

Emergency Contact: Name/Relationship________________________________Phone (___)______________

Injury Information

Referring Physician____________________________________Date of next appointment________________

Primary Care Physician____

Date of Injury______________________________ Date of Surgery (if applicable)________________________

Employment Related? ◯ Yes ◯ No Name of Employer______________________Claim#______________

Employer Address____Employer Phone________________

- Current Work Status: ◯ Fulltime ◯ Part-time ◯ Light-duty ◯ Time-loss

Auto Accident? ◯ Yes ◯ No Policy Number____________________Available PIP? ◯ Yes ◯ No

Adjuster/Claims Manager____Phone (____)________________

Attorney Name_____________________________Law Office Name________________________________

Insurance Information - *Please provide your insurance card and photo ID to patient coordinator*

Primary Insurance__________________________Secondary Insurance____________________________

Have you received any Physical, Occupational or Speech Therapy services since January 1, 2017? ◯ yes ◯ no

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

How did you hear about Sedro Woolley Physical Therapy?

◯ My Doctor ◯ Family Member ___________ ◯ Friend___________ ◯ Yellow Pages ◯ Internet

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SEDRO-WOOLLEY
Physical Therapy

Medical History Form

Patient Name:____ Date:____________________

Date of surgery/injury/problem began: (*be as specific as possible*)____
Describe briefly how you were injured____

____

Have you had any diagnostic testing for this issue? ◯None ◯X-ray ◯MRI ◯ CT Scan ◯Other__________

Have you had any prior treatment for this issue? ◯ Massage ◯ Chiropractic ◯ Injections ◯Other__________

Treatment side: ◯ Left ◯ Right ◯ Both Treatment location(back, neck,extremity______________________

Pain Levels and Descriptors

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 is best described as:

___Burning
___Sharp
___Dull/ achy
___Throbbing
___Shooting
___Numb/tingly
___Other____________

My pain or discomfort is:

___Decreasing
___Increasing
___Staying the same
___Intermittent
___Constant
___ Worse in the AM
___Worse in the PM

What activities/positions make you worse?____
What decreases your symptoms or makes you feel better?___________________________________

Medical History

Do you have a pacemaker? ____Yes ____No
Are you taking blood thinners? ____Yes ____No
Are you pregnant? ____Yes ____No
Have you had any falls in the past 12 months? ____Yes ____No

Please check if you currently have, or have had, any of the following conditions:

____No known significant past medical history to affect treatment

___Type 1 Diabetes
___Type 2 Diabetes
___Epilepsy/Seizures
___Osteoporosis
___Stroke
___Current Infection

___High Blood Pressure
___Cardiovascular Disease
___COPD or Emphysema
___Osteoarthritis
___Rheumatoid Arthritis
___Joint Replacement

___Cancer (type)______________________
___Allergies (list)_____________________
___Headaches
___Fibromyalgia
___Asthma
___Other_____________________________

Surgical History and Medications

Prior Surgeries/Dates____

____

List all medications you are currently taking (you may provide a list for us to copy if you choose)
Prescriptions____

____

Over the Counter Medication/Vitamins____

Updated 01/15/2017

Sedro-Woolley Physical Therapy

Policy updated 01/01/2017

FINANCIAL POLICY/CANCELLATION & NO-SHOW POLICY/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

CANCELLATION & NO-SHOW 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 $25 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.

If you fail to attend a scheduled appointment <u>without notification</u>, a $25 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.

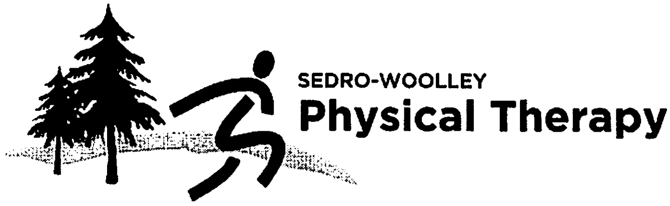
- I understand that Sedro Woolley Physical Therapy is not responsible for any personal belongings that I bring to the clinic.
- I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement or pending claims.
- I understand that 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 acknowledge that I have read, understand and agree to the cancellation and no-show policies as stated above.
- I understand that I am financially responsible for all charges related to a cancel or a no-show, and that **<u>these charges are not covered by my insurance</u>**, no matter what type of insurance I have.
- I hereby authorize and consent to treatment by Sedro Woolley Physical Therapy personnel.

Patient Name____

Patient Signature______________________________ Date______________

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

Witness Signature______________________________ Date______________



Sedro Woolley Physical Therapy Inc., P.S.
638 Sunset Park Dr., Ste 101
Sedro Woolley, WA 98284
Ph: (360) 856-4200
Website: www.swpt1.com

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

______________________________ ______________

Patient or Personal Representative Signature *Date*

______________________________ ______________

Witness *Date*

An updated copy of this Notice of Privacy Practices is located at www.swpt1.com and is also available at the scheduling desk.