Date_____

SEDRO WOOLLEY PHYSICAL THERAPY
PATIENT REGISTRATION

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 (___)_____

Physician & Claim Information

Referring Physician_____Date of next appointment_____

Primary Care Physician_____

Date of Injury_____ Date of Surgery (if applicable)_____

Employment Related? ☐ Yes ☐ No 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

Insurance Claims Manager_____Phone (____)_____

Attorney Name_____Law Office Name_____

Insurance Information

Primary Insurance_____Secondary Insurance_____

Have you received any Physical, Occupational or Speech Therapy services since January 1, 2020? ☐ Yes ☐ No

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

How did you hear about Sedro Woolley Physical Therapy?

☐ My Doctor ☐ Internet ☐ Returning Patient
☐ Family Member ☐ Sign on building ☐ Social Media
☐ Friend_____ ☐ Yellow Pages Other_____

We strive to provide the best service possible. You may receive a text or email to take a brief survey about your experience at SWPT.
If you do not wish to be contacted, please initial here: Initials_____Date_____

SEDRO WOOLLEY PHYSICAL THERAPY

Patient Name_____

MEDICAL CONDITION/INJURY/SURGERY INFORMATION

Please describe how you were injured and the location of your symptoms_____

_____

Date of onset, or date this issue began to interfere with your ability to function normally_____

Diagnostic Testing for this issue (*circle all that apply*) X-ray MRI CT Nerve Conduction Other_____

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
___Constant
___Other_____

My pain worsens with:

___Standing
___Walking
___Sitting
___Bending
___Stairs
___Lifting
___Reaching
___Other_____

What decreases your symptoms or helps you feel better?_____
Have you had any prior treatment for this issue?(massage, chiro, acupuncture etc...)_____

MEDICAL HISTORY

Do you have any of the following medical conditions? Please check YES to all that apply.

☐ **No known significant medical history to affect treatment**

	YES		YES
Pacemaker		High Blood Pressure	
Blood Thinners		Cardiovascular Disease	
Allergy to Latex		Cancer (type/date)_____	
Pregnancy		Fibromyalgia	
Fall Risk		Osteoarthritis	
Type 1 Diabetes		Rheumatoid Arthritis	
Type 2 Diabetes		Osteoporosis	
Stroke		COPD or other lung condition	
Parkinson's		Hearing deficits	
Current infection		Joint replacement (specify below)	
Allergies (specify)		Asthma	
Other (please list)			

Prior Surgeries/Dates_____

_____

Over the counter medication_____

Prescription Medication (you may provide a list for us to copy if you choose)_____

SEDRO-WOOLLEY
Physical Therapy

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 at the time services are rendered (for cash pay services) or upon the receipt of your bill. 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, 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 occasionally come up (illness, transportation issues, hazardous weather 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 without notification, 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 **these charges are not covered by my insurance.**
- 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_____

01.01.2020

SEDRO-WOOLLEY
Physical Therapy

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.

01.01.2020