Lake Washington PHYSICAL THERAPY

Patient Case Information

(Please Fill Out Forms Completely & Print)

(IF PATIENT IS UNDER 18 YEARS OF AGE LEGAL GUARDIAN MUST SIGN ALL PAPERWORK)

Patient Name:

(Last)_____ , (First) _____ (Middle Initial)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Mobile Phone :_____

Work Phone: _____ Email Address: _____

Date of Birth: _____ /_____ /_____ **SS#:** _____-_____-_____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ M ☐ S ☐ D ☐ W

Emergency Contact:

(Last)_____ , (First) _____

Relationship: _____Phone: _____

Employment Status: ☐ Student ☐ Working ☐ Retired ☐ Homemaker ☐ Unemployed

Employer: _____ Type of work: _____

Problem (Injured Region(s) of Body): _____

Date of Injury: ____/____/_____ (**Required:** Date is mandatory to trigger your insurance coverage)

Referring Physician: _____ Date of Physician visit: _____

Primary Care Physician:_____

Condition Related To: ☐ Employment ☐ Auto Accident ☐ Other Injury _____

Attorney: Yes ☐ No ☐ Attorney Contact: _____

How did you find Lake Washington Physical Therapy: ☐ Doctor ☐ Friend ☐ Family ☐ Yelp ☐ Google

☐ Facebook ☐ Former Patient ☐ Lecture ☐ Walk by ☐ Other_____

Patient / Guardian Signature: _____**Date:**_____

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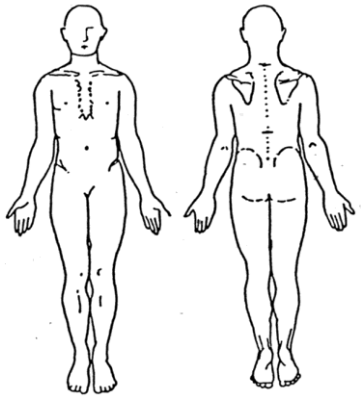
Functional & Symptom Questionnaire

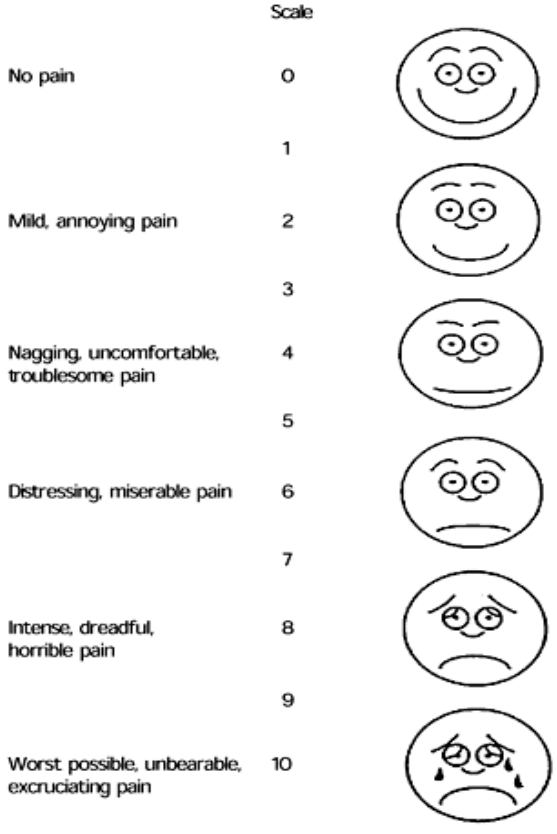
Are your symptoms? ☐ improving, ☐ becoming worse, or ☐ staying the same?

A. (Please Circle or Mark Painful or injured areas)



B. Pictorial Pain Assessment Scale:

Which one of the following best describes your pain? (Patient can reply by circling the words, numbers or pictures.



Patient / Guardian Signature: _____Date:_____

Lake Washington PHYSICAL THERAPY

Medical History

Past	Current		Region & Date
☐	☐	Physical Therapy	☐ Acupuncture _____
☐	☐	Ergonomics Evaluation	☐ CT Scan _____
☐	☐	Chiropractic	☐ MRI _____
☐	☐	Emergency Room Care	☐ Bone Scan _____
☐	☐	Massage Therapy	☐ X-Rays _____

Please list any surgeries/procedures you have had for this injury: _____
Days a week do you perform physical activity? _____
Are you aware of your diagnosis and prognosis as explained by your doctor? ☐ Yes ☐ No
Please list any current medications (prescribed and over the counter):
_____
Do you currently have or have past medical history of any of the following; Mark/Circle if necessary:

☐ Asthma,
☐ Bronchitis, or
☐ Emphysema
☐ Headaches
☐ Shortness of Breath
☐ Lung Problems
☐ Chest Pain
☐ Visual Difficulties
☐ Hearing Difficulties
☐ Coronary Heart Disease
☐ Angina
☐ Pacemaker
☐ Dizziness or Fainting
☐ High Blood Pressure
☐ Bowel / Bladder Problems
☐ Heart Attack
☐ Heart Surgery
☐ Weakness
☐ Stroke
☐ Seizures/Epilepsy
☐ Weight Loss/ Fatigue

☐ Congestive Heart Failure
☐ Hernia
☐ Blood Clot/ Emboli
☐ Varicose Veins
☐ Latex Sensitivities
☐ Allergies
☐ Allergies Tapes/Lotions
☐ Thyroid Disease
☐ Goiter
☐ Pins or metal implants
☐ Anemia
☐ Shoulder Injury/Surgery
☐ Infectious Disease
☐ Neck Injury/Surgery
☐ Diabetes
☐ Kidney Problems
☐ Liver Problems
☐ Joint Replacement
☐ Cancer
☐ Elbow/Hand Injury/Surgery
☐ Arthritis

☐ Back Injury/Surgery
☐ Osteoporosis
☐ Knee Injury or Surgery
☐ Gout
☐ Leg/ Ankle Injury/Surgery
☐ Broken Bones/ Fractures
☐ Pain with sneezing
☐ Pregnant(Current/ Past)
☐ Depression
☐ Tobacco
☐ Hypoglycemia
☐ Fibromyalgia
☐ Chronic Pain
☐ Eating Disorders
☐ Head Injuries
☐ Neurological Deficits
☐ Metal Implants
☐ Other:
_____

Please list any other information that you believe would assist the therapist in your care:
_____

What are your rehabilitation expectations and goals in this program other than pain relief?
_____

Patient / Guardian Signature: _____ **Date:** _____

Lake Washington PHYSICAL THERAPY

Consent for Treatment

I agree to give my consent for *Lake Washington Physical Therapy, LLC.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition. This could be in any agreed upon delivery method; In clinic, via TeleHealth services, or as Delivered care to your home or office.

Name of Patient: _____
(Please print complete name)

Authorization for Disclosure of Medical Records

I authorize *Lake Washington Physical Therapy, LLC.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

eMail Privacy Statement

Lake Washington Physical Therapy's Therapists like to stay in close contact with patients. We will be using secure email and Zoom video conferencing during your treatment to send pertinent information regarding your account, recovery, home exercise programs (HEPs) and progress updates. Our office is committed to your privacy and will not sell, disseminate, or give your email address to 3rd parties.

Information Privacy Statement

Lake Washington Physical Therapy, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

I understand and agree to *Consent for Treatment in the clinic, TeleHealth, or at home; also the Authorization for Disclosure of Medical Records, and the Information Privacy Statement* above:

Patient/ Guardian _____ **Date:** ___/___/___

Lake Washington PHYSICAL THERAPY

Financial Policy Statement

Lake Washington Physical Therapy, LLC will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. **If your insurance company does not remit payment within 60 days, the balance will be due in full from you**. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance per your insurance contract.
Co-Pays & Co-Insurances are always due at the time of service.

Billing Policy for Lake Washington Physical Therapy

If we are billing your insurance company please contact your insurance company for information regarding your physical therapy benefits. As a courtesy our office staff will verify insurance coverage, but this is not a guarantee. It is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment. *(Ask our front office if you have questions).*
☐_____ *I Understand an insurance* ***quote is not a guarantee*** (initial)

Balances owed to Lake Washington Physical Therapy

- **Each visit until insurance deductible is met a deposit is due at service**
  - **$150 deposit for Evaluations**
  - **$125 deposit for Daily / Return Visits**
- Balances unpaid after 30 days will accrue a $45.00 fee each billing cycle.
- Balances unpaid after 60 days must have payment arrangements with our billing office.
- Balances unpaid after 91 days will be turned over to our collection agency.

*Checks returned with non-sufficient funds will be charged a $45.00 fee.

Lake Washington Physical Therapy Cancellation/ No-Show Policy

- Lake Washington Physical Therapy appointments scheduled represent time set aside specifically for you as a patient. All cancellations must be made at least **24 hours** prior to the scheduled visit. Patients who cancel or No-show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the primary physical therapist.
- By law, all cancellations, and No-shows involving Worker's Compensation claims must be reported to your physician and your claims adjuster.
- **All Cancellations (less than 24 hour notice) and No-show appointments will be charged a fee of $45.00 to your account.** This fee is due before or at the time of your next physical therapy visit. (charges removed from your account balance by bringing in 4 cans of food per missed appointment)

I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with *Lake Washington Physical Therapy, LLC*. I understand and agree to the financial policy statement, billing policy statement, and cancellation policy.

Patient/ Guardian _____**Date: ___/___/___**

Lake Washington PHYSICAL THERAPY

Appointment Reminder and Consent

Complete this form and sign below to give your permission for Lake Washington Physical Therapy to provide you with appointment notifications. **By default, our appointment reminder notifications are sent via text message.** If you would prefer a phone call or email reminder instead, please fill out the following information.

☐ **Email:** Lake Washington Physical Therapy may send email messages to confirm my upcoming appointment to _____ .

☐ **Phone:** I prefer to receive phone call reminders at this phone number_____.

***Our cancellation list notifications will also be sent via text, unless specified above.**

TeleHealth & LWPT Delivered Visits Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications.

- I understand that Telehealth visits involve the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visits at any time. This will not change my ability to receive future care at this office.
- I understand that Telehealth billing information is collected in the same manner as a regular LWPT office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s) or Medicare and it is my responsibility to check with my insurance plan to determine coverage and out of pocket costs.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of Telehealth & Delivered visits in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
    - Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
    - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I agree that information exchanged during my Telehealth visits will be maintained by the physical therapists, physicians, and healthcare facilities involved in my care.
- I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

Patient / Guardian Signature: _____Date:_____

Lake Washington PHYSICAL THERAPY

LWPT Delivered Visit Consent

In LWPT Delivered Visits one of our licensed physical therapists will come directly to your home, gym, or office and use digital technology to communicate with our HIPPA compliant server.

- I understand that Delivered Visits involve the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the Delivered visits at any time. This will not change my ability to receive future care at this office.
- I understand that Delivered billing information is collected in the same manner as a regular LWPT office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s) or Medicare and it is my responsibility to check with my insurance plan to determine coverage and out of pocket costs.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of Delivered visits in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
    - Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
    - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I agree that information exchanged during my Delivered visits will be maintained by the physical therapists, physicians, and healthcare facilities involved in my care.
- I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.
- I agree to create a safe and inviting environment prior to the arrival of my physical therapist at my home, gym, or office. This includes but is not limited to:
    - Putting all pets away during the allotted treatment time
    - Creating a space in the living or family room that is big enough to have a traveling treatment table set up and an safe area to perform exercises
    - Having a table with two chairs available for the interview process
    - I will have a sink available with soap and towels to allow our therapist to wash before and after treatment
- I understand that my therapist may take the precaution to wear gloves or a medical mask to offer additional protection

Patient / Guardian Signature: _____Date:_____