QUALITY CARE PHYSICAL THERAPY

Sports Rehabilitation
Work Injuries
Pre & Post Surgery Rehab
Orthopedics
Biomechanical Analysis
Spine Rehabilitation
Motor Vehicle Accidents
Dance Rehabilitation

PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ M.I.____ Date of Birth ___/___/___

Address_____ Apt#_____ City, State _____ Zip Code_____

Home # (_____) _____ Cell # (_____) _____ Social Security #: _____-_____-_____

Emergency Contact: _____ Relationship: _____ Phone# (_____) _____

Employer: _____ Work # (_____) _____

APPOINTMENTS

How would you like to receive your courtesy reminder for upcoming appointments?

□ Text Message (*rates may apply from your provider*) □ Email_____

Do we have permission to leave a detailed message regarding appointments on your answering machine? □ Yes □ No

INSURANCE

Is the reason for your visit today related to a car accident or work injury? □ Yes □ No

Is your insurance a Medicaid or Community Health Plan? □ Yes □ No

Are you the main subscriber on the insurance? □ Yes □ No If you checked no, please provide us:

Main Subscriber's Name:_____ Date of Birth: _____

Main subscriber's Address & Phone #:_____

Do you have a secondary insurance? □ Yes □ No

If yes, have you contacted your insurance to set up a coordination of benefits? □ Yes □ No □ N/A

HOW DID YOU HEAR ABOUT US

Check all that apply, **be sure to list the Friend or Family Member that referred you.**

Friend/ Family Name:_____

□ Quality Care PT Website
□ Returning Patient
□ Insurance Website
□ Doctor Referral
□ Google
□ Other _____
□ Facebook
□ Yelp

APPOINTMENT CHECKLIST

On your first visit it is important that you arrive on time as you will be meeting with our front office staff for registration. Please be sure to bring the following:

- Driver's license
- Insurance card
- A referral from your doctor
- Co-pay (if applicable)
- Completed and signed registration forms
- Appropriate clothing to expose entire injured area such as shorts or a T-shirt
- Request your physician fax surgical report and any test results to 425-486-7077

Our front office staff will be happy to assist you and answer any questions you may have regarding policies and scheduling. Thank you for choosing Quality Care Physical Therapy for your physical therapy needs. You will love our clinic and we look forward to meeting you.

April 2018

18404 102nd Ave NE, Suite A, Bothell, WA 98011 Phone 425.486.6079 Fax 425.486.7077
Info@QualityCarePT.com www.QualityCarePT.com

To ensure the safety of our patients as well as our staff please be advised that Quality Care Physical Therapy is equipped with video surveillance in all open common areas inside and outside of the facility.

RECEIPT OF PRIVACY PRACTICES/EMAIL PRIVACY STATEMENT/TEXT MESSAGING

By signing below, you acknowledge that you were given/offered a copy of the Notice of Privacy Practices of Quality Care Physical Therapy. You are authorizing Quality Care Physical Therapy to release your records to your insurance company and physician as needed. Your records are held in strict confidence and we will not release them to any unauthorized person. By sending an email or text message to Quality Care Physical Therapy requesting information, you are thereby authorizing correspondence that may contain personal information that is not secure. We will not sell or give your email address to 3rd parties. Our Notice of Privacy Practices posted online and in our office provides further information about how we may use and disclose your protected health information, and we encourage you to read this document in full.

Signed:_____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

CONSENT TO RECEIVE TREATMENT

I voluntarily give Quality Care Physical Therapy my consent to receive services which may include diagnostic procedures, examinations, and treatment according to the recommended plan of treatment as discussed with my therapist. I understand that physical therapy involves manual techniques that require appropriate physical contact by the health care provider and staff.

Signed:_____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

NO-SHOW/CANCELLATION POLICY

Please notify our office 24 hours in advance or more if you must reschedule your appointment.

- Late Cancellations (cancellations LESS than 24 hours prior to the scheduled therapy visit) are costly to our office and will be charged a **$50.00** fee directly to the patient. The Quality Care Physical Therapy staff will do their best to fill the canceled appointment slot in order to help eliminate this cancellation fee.
- No-Show (appointments not held by the patient, with no call made to our office to notify of cancellation of the agreed upon appointment) will be charged **$110.00** directly to the patient.
- By law, all cancellations and No-shows involving Worker's Compensation claims must be reported to your physician and your claims adjuster.
- Two "No-Show's" and/or multiple cancellations will result in the loss of your future scheduled time slots reserved for you. Future visits may be scheduled 24 hours in advance or will be put on a waiting list and we will call you per the availability on our schedule.
- Please note that all copays are due at time of service. A **$25.00** billing fee will be charged for copays not paid at time of service.

It is not our intention to cause undue financial hardship; however, in order to maintain our standard of care, we must collect our receivables as efficiently as possible. **All fee's are due at the time of the next scheduled visit.**

I have read and understand the Cancellation Policy for Quality Care PT. Returned check fee is $35.00 per occurrence.

Signed:_____ **Date:**_____
(Parent/Guardian's signature if child is under 18 years old)

FOR USE BY OFFICE: Witnessed by _____

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AUTHORIZATION & FINANCIAL AGREEMENT
PLEASE READ CAREFULLY:

I consent to the physical therapy rendered to me (or the person to whom I am legally responsible) that is determined to be necessary by the physical therapist and/or physician.

Financial Agreement:

I hereby authorize all payments on this claim to go directly to Quality Care Physical Therapy.

If health insurance companies require a physician's referral, each patient must have a written prescription from their referring doctor stating the diagnosis that they need physical therapy for and the current date.

If your insurance company does not remit payment within 60 days on timely filed claims, 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 Quality Care Physical Therapy. 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.

All accounts in litigation will be billed directly to patient. We do not accept 3rd party claims.

For your convenience we submit claims to your insurance company; however, it is your responsibility to follow up with your insurance company regarding coverage of treatment provided.

Billing Agreement:

All accounts are billed monthly. Payment is expected within 30 days after the first statement is sent and is considered past due if a second statement is sent.

- Balances unpaid after 30 days will accrue a $35.00 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 and subject to an additional $7.00 service fee. Accounts in collections forfeits future treatment at Quality Care Physical Therapy.

All patients are ultimately responsible for knowing what their insurance benefits are and what treatments and modalities are covered under their policy. All patients are responsible for preauthorizing visits if their insurance requires that for payment.

My signature below indicates: I HAVE READ THE ABOVE PAYMENT POLICIES AND AGREE TO THE TERMS OF THESE POLICIES. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO ENFORCE PAYMENT OF ANY CHARGES, I AGREE TO BE RESPONSIBLE FOR AND PAY ALL ATTORNEY'S FEES AND COURT COSTS INCURRED.

Patient's Printed Name: _____ Date: ____/____/____

Patient's Signature: _____

(Parent/ Guardian's signature if child is under 18 years old)

April 2018

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Medical History

Patient Name: _____ **Date of Birth:** ____/____/____

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Conditions	Medical Precautions

Fall History

☐ Injury as a result of a fall in the past year?
☐ Two or more falls in the last year?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ **Currently not taking any medications**

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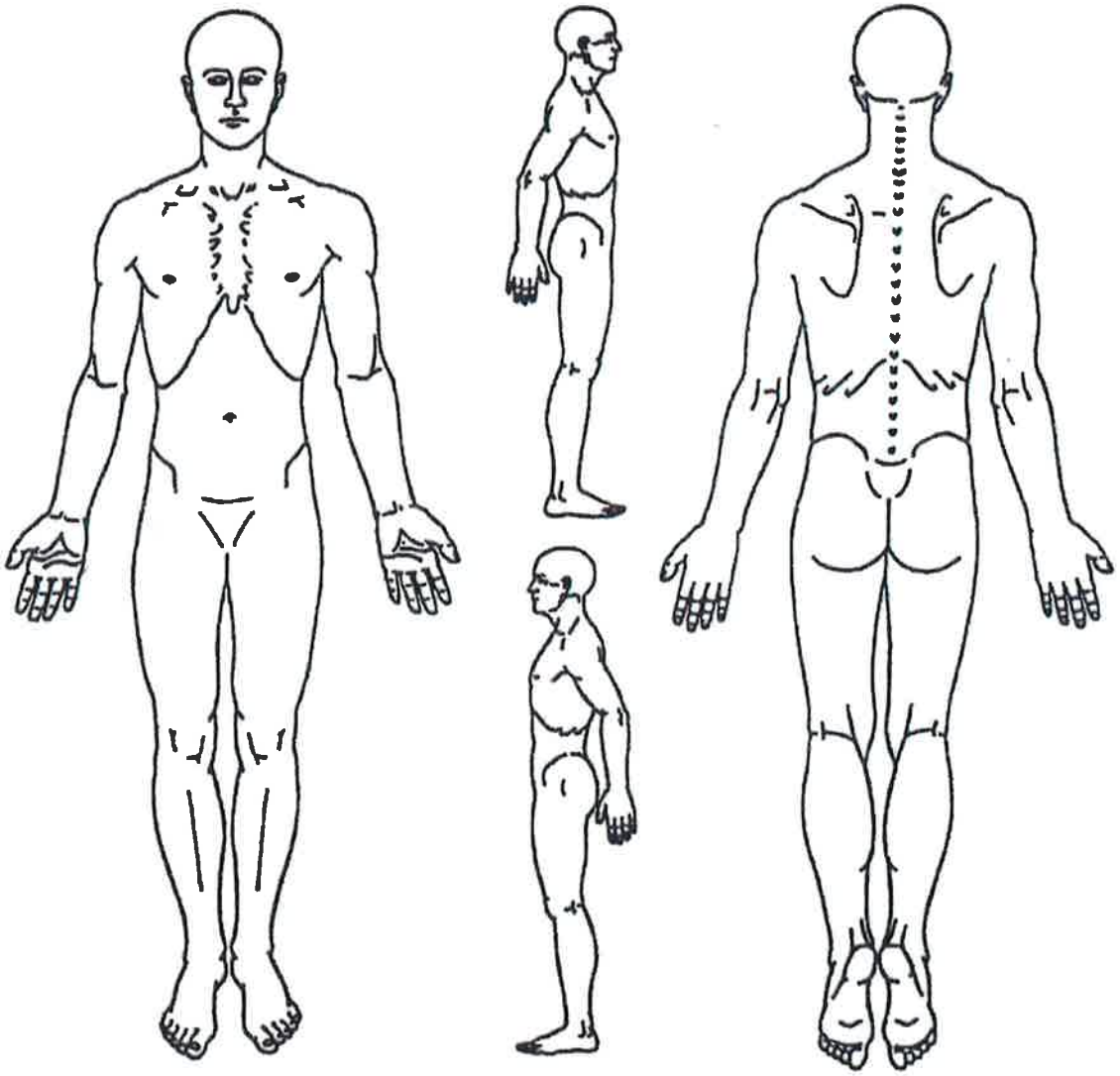
NAME: (please print)_____

PAIN DIAGRAM

On the diagram below, please mark the area(s) you are experiencing symptoms please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

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