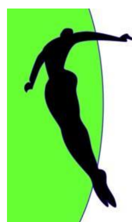

PATIENT & INSURANCE INFORMATION

Patient Information:

First Name________________________________Middle I.__________Last Name _____________________________________

If patient is a minor: Parent(s) name(s) ____

Address____Apt. ____________________________

City____State__________________Zip___________________

SSN _________-________-________________ Gender____________ Birthdate____

E-mail (for appointment reminders) ____

Home Ph____________________________Work Ph____________________________Cell Ph ______________________________

Preferred number Home________________________ Work____________________________ Cell ____________________________

Appointment Reminder Preference E-mail ____ Phone call __________________

Emergency contact: Name____Phone ____________________________

Referring Doctor:____Phone ____________________________

Primary Doctor:____Phone ____________________________

Who may we thank for referring you? Physician/health care provider Internet/Social Media Neighborhood

Friend / family Other ____ ___

Insurance Information: *Complete this section only if you are unable to provide a copy of your insurance card.

Primary Insurance: *(Please let us know if you are covered by more than one insurance company.)*

Insured's Name____Birthdate______________________________

Insurance Co.____Cust. Service Phone ______________________________

Member ID#____Group # ____

▸ ***<u>Was your injury the result of a WORK or AUTO accident</u>? If so, please provide insurance info above AND complete this section:***

Claim #____Date of Injury____

Claims Manager______________________________________Claims Mgr. phone ______________________________________

Insurance Carrier______________________________________Claims Address ____

Billing Information: Bill to patient address above ____ <u>OR</u> Bill to responsible party below ____

Name____Phone ____________________________

Address ____

City____State__________Zip__________________

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:
I understand, as the patient and/or above-mentioned responsible party, that I am fully responsible for payment of all charges incurred. This includes any deductibles, non-covered services, or non-authorized services. I assign all medical payment to Biojunction Sports Therapy.

I hereby authorize the release of any medical information necessary to secure payment for services rendered.

Patient Signature:____ Date:__________________________
(*Parent or guardian, if patient is minor)*

CONFIDENTIAL

Patient Name:______________________

MEDICAL INFORMATION

1. What are we seeing you for? ____

____

2. Describe how and when your symptoms began *(Give specific date, if applicable)*: ______________________

____

3. Overall, are your symptoms: (circle one) improving getting worse unchanged

4. On a scale of 0-10, with 0 being "No pain at all" and 10 being "Worst pain imaginable", for the last week please rate your

level of discomfort: At **WORST**_______/ 10; At **BEST**_________/ 10; What is it **CURRENTLY**:_________/ 10

5. Have you had similar symptoms in the past? *(if so, when?)*_____________________________________

6. Describe your symptoms: (circle all that apply) sharp dull numbness/tingling throbbing shooting aching burning other____

7. What aggravates your symptoms? ____

8. What eases your symptoms? ____

9. Have you had any special tests regarding your symptoms (MRI, X-Ray, CT Scan, Ultrasound, EMG, bone scan)? Y N

If yes, results? ____

10. Since your symptoms began, have you had any of the following: (circle all that apply)

Bowel or bladder issues	Weakness	Dizziness or fainting	Fever/chills/sweats
Significant weight change	Hearing or vision problems	Numbness or tingling	Difficulty swallowing
Pain at night	Numbness in the genital area	Nausea/vomiting	NONE

11. Please list your: Height ___________ Weight ___________

12. Allergies ____

13. Current medications ____

13. Major surgeries/injuries since birth ____

____

14. Are you currently being treated by:

Another physical therapist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Chiropractor	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Massage Therapist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Acupuncturist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Other __________________	Yes_____	No_____	Or within the last 12 months	Yes_____	No_____

15. Are you currently pregnant? Yes___ No__ N/A______

16. Do you smoke? Yes___ No___

17. Do you drink alcohol? Yes___ No___ How many drinks/week?_________

18. Do you currently have, or have you had a history of the following? (circle all that apply)

Alcoholism	DVT/ Blood clot	Multiple Sclerosis
Anemia	Emphysema	Osteoporosis/Osteopenia
Anxiety	Falls/Loss of balance	Pacemaker
Arthritis	Fibromyalgia	Parkinson's Disease
Artificial joints	Fractures	Pulmonary Embolism
Asthma	GERD	Rheumatoid Arthritis
Atrial Fib	Headaches/Migraines	Sensitivity to heat or ice
Cancer	Heart Attack	Seizures
Chemical dependency	Heart Murmur	Shortness of breath
Congestive Heart Failure	Hepatitis	Sleep Disorder/Apnea
COPD	HIV/AIDS	Stress fracture
Coronary Artery Disease	High Cholesterol	Stroke/TIA
Crohn's Disease/ Ulcerative Colitis	High Blood Pressure	Substance Abuse
Depression	Kidney Disease	Thyroid disease
Diabetes	Loss of menses	Ulcers
Dizziness/Vertigo	Late onset of menses	Other ___

19. Exercise or activities that you enjoy: ______________________________

20. Occupation: ______________________________

21. Are you currently able to perform all your regular work/home duties? Yes___ No___

The above information is true and accurate to the best of my knowledge.

Patient Signature:______________________________ Date:____________________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Biojunction Sports Therapy to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of the presenting physical condition(s) to the patient named below.

Patient Name:______________________________

Patient Signature: ______________________________ Date: ____________________

(*Parent or guardian, if patient is minor)*

FINANCIAL POLICY STATEMENT

Insurance Billing:

- As a courtesy to our patients, we will bill your insurance(s) based on the information you provide.
- All co-pays are due at time of service. Other costs (e.g., deductible, co-insurance) will be billed to the patient or responsible party after the insurance has processed your claims.
- Please be advised that it is your responsibility to know the limitations and/or restrictions of your insurance company/plan regarding physical therapy treatment and orthotics. We recommend that you contact your insurance company prior to your first appointment to verify your coverage for outpatient physical therapy, and to determine if your plan requires a prescription or referral from your physician.

Please understand that you are financially responsible for any deductibles, co-pays, and non-covered, or non-authorized services.

Interest Charge/Collections Fees:

- Any balance remaining after 60 days from the billing date will incur an interest charge at the rate of 1% per month, 12% annually.
- If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and/or a reasonable attorney fee.

For L&I Claims:

- Be advised that you may be responsible for your charges if your Workers' Compensation claim is closed or denied.
- If you miss two (2) scheduled appointments without 24 hours notification, your claims manager will be contacted and you may be held responsible for the No-Show fee(s).

I have read the above information and/or it has been explained to me, and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name:____

Patient Signature:_____________________________________ Date:______________________

(*Parent or guardian, if patient is minor)*

CANCELLATION AND NO-SHOW POLICY

We ask that you please give one full business day's (minimum 24 hours) notice in advance to cancel an appointment. Any no-show or late cancellation within 24 hours of the scheduled appointment time will result in a cancellation charge of **$75.00.** This charge cannot be billed to your insurance.

Physical therapy is most effective when the patient is an active participant in their home exercise program and when they attend all appointments prescribed by their therapist. Therefore, it is very important that you attend all scheduled appointments.

If a cancellation is unavoidable, we ask that you give as much notice as possible so that we may offer the appointment to another patient. If you arrive more than 15 minutes past your scheduled appointment time, we may ask you to reschedule that appointment or may offer you a shorter treatment time based on what our schedule allows.

I have read the above information, and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name:____

Patient Signature:____ Date:_______________________

(*Parent or guardian, if patient is minor)*

NOTICE OF PRIVACY PRACTICES (Required by law)

Biojunction Sports Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

- We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

- Our clinical and front office staffs use patient information to ensure quality care and appropriate billing for services.

- You may correct, amend, access, and request a copy of your medical records by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

- We protect all patient information within the guidelines provided by federal, state, and local government.

- If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Billing Manager at 206-829-8269.

- Biojunction Sports Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

- It is okay to call and leave a detailed message regarding medical appointments.
  Yes / No initial: _________

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.

Patient Name:____

Patient Signature:______________________________________ Date:______________________

(*Parent or guardian, if patient is minor)*