

Dear New Patient,

Thank you for choosing Biojunction Sports Therapy. We look forward to meeting you!

Enclosed you will find some information that will help you get to know us and allow us to know more about you and the reason that you are visiting our clinic. It is helpful if these forms are fully completed prior to the start of your first appointment.

Please bring the following to your first appointment:

- All completed registration and medical history forms.
- Your doctor's written prescription, especially if required by your insurance.
- Your insurance card and photo ID so that we may photocopy the necessary information.
- Comfortable clothing, preferably that will allow easy access to the body part being treated.

If you are being evaluated for orthotics, please also bring:

- A selection of the shoes you wear daily and/or are active in (sport shoes, work shoes, etc.).
- A pair of shorts or pants which can be rolled above the knee.

Please plan to spend 45 to 60 minutes for your initial evaluation. Should you have any questions regarding your appointment, feel free to call our office at:
West Seattle (206) 938- 0860; Wallingford (206) 829-8269.

Thank you!

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 # _____

▶ Was your injury the result of a WORK or AUTO accident? 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 _____ OR 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)

Patient Name: _____

CONFIDENTIAL 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. Allergies _____
12. Current medications (**Medicare pts. DO NOT fill out, use separate handout**) _____

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

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 (Circle one & 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)