



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 (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: Columbia City (206) 327-9907; Georgetown (206) 932-7943; Wallingford (206) 829-8269; West Seattle (206) 938-0860

Thank you!



PATIENT & INSURANCE INFORMATION

Patient Information:

First Name: _____ Middle Init.: _____ Last Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

SSN: _____ - _____ - _____ Patient Birthdate: _____

Sex assigned at Birth: _____ Gender Identity: _____ Preferred Pronouns: _____

*** If patient is a minor: Parent(s) name(s): _____ Guarantor/Parent(s) Birthdate: _____**

Email (for appointment reminders): _____ Appt. Reminder Preference (please circle): Email Phone

Preferred Contact Number: _____ Home / Work / Cell (please circle)

Emergency Contact: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Who may we thank for referring you? Physician/Healthcare provider _____ Internet/Social Media _____ Neighborhood _____

Friend/Family _____ Insurance search _____ Other (please list): _____

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: _____

Claim Manager: _____ Claim Mgr. Phone: _____

Insurance Carrier: _____ Claim Address: _____

Billing Information: Bill to patient address above _____ OR Bill to responsible party below _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____



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," please rate your level of discomfort for the last week: 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. 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
8. What aggravates your symptoms? _____
9. What eases your symptoms? _____
10. Have you had any special tests regarding your symptoms (MRI, X-Ray, CT Scan, Ultrasound, EMG, bone scan)? Yes / No
If yes, results? _____
11. Allergies: _____
12. Current medications prescribed or over the counter (**Medicare pts. DO NOT fill out, use separate handout**): _____

13. Are you currently being treated by: (circle all that apply)

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
14. Are you currently pregnant? N/A No Yes How many weeks/Due date? _____
15. Do you use tobacco products? Yes No How much? _____ Former user? Yes Date stopped? _____
16. Do you drink alcohol? Yes No How many drinks/wk? _____ Former drinker? Yes Date stopped? _____



17. In what position do you sleep? _____ How many hours are you getting on average? _____
 18. Do you currently have, or have you had a history of the following? (Circle all that apply)

Cancer (Type/s): _____

Cardiovascular System:

- Atrial Fib.
- Congestive Heart Failure
- Coronary Artery Disease
- DVT / Blood Clot (Date) _____
- Heart Attack (Date) _____
- High Cholesterol
- High Blood Pressure
- Pacemaker

Respiratory System:

- Asthma
- COPD
- Emphysema
- Pulmonary Embolism
- Shortness of breath

Auto Immune Disorders:

- Crohn's Disease / Ulcerative Colitis

Diabetes (Type) _____

- Fibromyalgia
- Multiple Sclerosis
- Thyroid Disease

Brain / Blood Systems:

- Anemia
- Dizziness / Vertigo
- Headaches / Migraines
- Hepatitis
- HIV / AIDS
- Kidney Disease
- Loss of menses
- Late onset of menses
- Parkinson's Disease
- Seizures
- Sleep Disorder (describe) _____
- Stroke / TIA (where/when) _____

Digestive System:

- Eating Disorder _____
- GERD
- Ulcers

Mental Health System:

- Alcohol / Chemical Dependency
- Anxiety
- Depression

Musculoskeletal System:

- Arthritis (Type) _____
- Artificial joint(s) (list) _____
- Falls / Loss of balance
- Fractures (where/when) _____
- Stress Fractures (where/when) _____
- Osteopenia / Osteoporosis
- Sensitivity to heat or ice

Other not listed: _____

19. Major surgeries/injuries since birth: _____
 20. Exercise or activities that you enjoy: _____
 21. Occupation: _____
 22. Are you currently able to perform all your regular work/home duties? Yes No
 23. Goals for Physical Therapy: _____

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. I understand this may include the use of medical tools/instruments including but not limited to cups, soft tissue mobilization tools, taping, and blood flow restriction devices, which may cause skin reactions, bruising, or soreness. I will disclose any of these reactions to my physical therapist so that treatment can be adjusted if necessary.

Patient Name: _____

Patient Signature: _____ **Date:** _____

(Parent or guardian if patient is a 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.

★ A convenience fee of 3% will be added to all credit card charges.

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.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:

I have read the above information and/or it has been explained to me, and I accept the terms and conditions of the above. 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 Name: _____

Patient Signature: _____ **Date:** _____

(Parent or guardian if patient is a minor)

3727 California Ave SW, Suite 1-A • Seattle, WA 98116 • Phone: 206.938.0860 • Fax: 206.938.0866
4005 Wallingford Ave N • Seattle, WA 98103 • Phone: 206.829.8269 • Fax: 206.829.8594
4634 E Marginal Way S. #C-120 • Seattle, WA 98134 • Phone: 206.932.7943 • Fax: 206.932.8686
4689 Martin Luther King Jr Way S, Suite 2 • Seattle, WA 98108 • Phone: 206.327.9907 • Fax: 206.327.9928
Email: info@biojunction.com • Website: www.biojunction.com

CANCELLATION AND NO-SHOW POLICY

We ask that you please give one full business day (minimum 24 hours) notice in advance to cancel an appointment. Business days are considered Monday through Friday. 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.

If you fail to show for two appointments in a row without advance notice or cancel within 24 hours (including no-shows) for three consecutive appointments, you may be moved to a Same-Day policy where you will only be offered appointments available on the same day that you call. We also reserve the right to cancel all future appointments as an alternative action.

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 a 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 staff 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 AND 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 a minor)