Eastside Sports Rehabilitation Clinic

Personal Information

Patient Name _____ Mr. Ms. Miss Mrs.

Last First Middle

Today's Date: _____

Address _____

Home Phone (_____) _____-_____

_____

Work Phone (_____) _____-_____

City State Zip

Mobile Phone (_____) _____-_____

Birth Date _____

Email _____

Monthly statements will be sent to the email address provided.

☐ ***I agree that the email listed above is correct and current.***

Marital Status ____Single ____Married ____Other

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Nature of Injury/Symptom

Whom may we thank for referring you to this office? _____

Primary Care Physician _____

Date of Injury / Symptom _____ Body Part Involved _____ *right or left*

Cause of Injury _____

Billing Information

If Other than Patient, Insurance Subscriber Information:

Patient's Occupation_____

Patient's Employer_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Phone _____

Subscriber Name _____

Address _____

Home Phone _____

Work Phone _____

Subscriber's Birth Date _____

Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Did your injury happen at work? ____ Yes _____ No

Date of Accident _____ Employer at time of Injury _____

Insurance Company _____ Claim Number _____

Were you involved in a motor vehicle accident? _____ Yes _____ No

Date of Accident _____ Insurance Company Name _____

Claim Number _____

Have you seen another physical therapist in the last 90 days? _____ If yes, when was your most recent visit? _____

EASTSIDE SPORTS
REHABILITATION CLINICS

General Health Questionnaire

Eastside Sports Rehabilitation Clinic

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we can provide you the best possible care.
Check any problems below that you have now and/or have had trouble with in the past.

____Chest Pain
____Heart Attack
____High Blood Pressure
____Low Blood Pressure
____Poor Circulation
____Difficulty Breathing
____Tuberculosis
____Respiratory Disease
____Numbness to Hands and Feet
____Head Injury
____Stroke
____Seizures
____Difficulty with Balance
____Frequent Falls
____Blackouts
____Other Orthopedic Injuries

____Osteoarthritis
____Rheumatoid Arthritis
____Hepatitis
____Blood Clots
____Diabetes
____Bleeding/Bruising Easily
____Hearing Impairment
____Visual Impairment
____Skin Rash/Disease
____Severe Night Pain
____Cancer
____Night Sweats
____Osteoporosis
____Bladder Problems
____Surgery Please list:
_____

Do you smoke? _____
Do you exercise? _____ If so, how often? _____
Do you get short of breath with exertion (up/downstairs)? _____ Is there any chance of pregnancy?_____

Please list any medications you are taking: _____

List some activities that seem to aggravate your injury/problem area _____
_____

List some activities that seem to relieve your injury/problem area _____
_____

_____ _____ _____

Patient Signature *Parent / Guardian Signature* *Date*

EASTSIDE SPORTS
REHABILITATION CLINICS

Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received, regardless of insurance coverage.

Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day that treatment is rendered. The self-pay discount is 35%.
2. If you do not pay at the time services are rendered, you will be charged a finance charge and billed the same day.

Payment options if you have insurance:

1. You choose to pay your deductible of and any out-of-pocket portions at the time services are rendered by cash, check, or credit card. We will then bill your insurance and reimburse you for any credits on the account.
2. You choose to pay all your treatment by cash, check, or credit card.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive copays at the beginning of your visit.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in King County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation: We require written approval/authorization by your employer and or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

- **Missed Appointments and Late Cancellations:** Our therapists value your time and request that you value theirs. Appointments cancelled, and/or rescheduled less than **24 hours prior** to the scheduled appointment time will be charged **$100.00 each**.
- For **Monday appointments**, cancellations must be made by **1:00pm on the Friday** prior to your appointment.
- **Late Arrival:** Arriving 10 or more minutes late with be considered a late cancellation and you will not be seen for the appointment.
- Missed appointment fees must be paid at the next scheduled appointment. For appointments that are a No-Show without any notice given, the charge will be **$150.00 each**.

These charges cannot be billed to your insurance company and will be your responsibility.

Initial to confirm you have read the Late/Cancellation Policy: _____

Patient Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____

Cancellation Policy

Late Cancellation Fee - $100

No Show Fee - $150

If you need to cancel or reschedule any appointments, please let the front desk staff know at least a full 24 hours in advance (or by 1pm on Friday if calling about an appointment on the following Monday) to avoid being charged our **late cancellation fee ($100)** or our **no show fee ($150).** These charges cannot be billed to insurance and will be patient responsibility, due by your next scheduled appointment.

Late cancellations include any phone calls, voicemails, emails, or in person conversations asking to cancel or reschedule an appointment less than 24 hours before that appointment is set to occur (1pm on Friday if calling about an appointment on the following Monday).

- We strive to provide timely service to all our patients. If you expect to be 5 or more minutes late, please give us a call to let us know. Arriving 10 or more minutes late to your appointment will be considered a late cancellation, you will be charged a late cancellation fee, and you will not be seen for your appointment that day.

- Rescheduling to a different date does not nullify the late cancellation fee. “Late cancellations” includes any reschedules that are made less than 24 hours before that appointment is set to occur (1pm on Friday if calling about an appointment on the following Monday).

For all appointments we send out reminders via text or email 48 hours before your scheduled appointment. Keep in mind these reminders are a courtesy, and patients are required to manage their own schedule.

- Responding to any of the automated reminders does not reach the front desk staff, therefore is not a valid way to cancel an appointment.

Please give us a call if you need to make any scheduling changes or have any additional questions, our phone number is (425)-576-8180 option 1. We’re open Monday - Friday 6:30am to 6:00pm.

We appreciate your understanding and cooperation with the policy.

I, _____, acknowledge that I have read and understand the cancellation policy outlined above. I agree to abide by the terms above and failure to do so will result in the corresponding fees being applied to my account.

Signature: _____ Date: _____

EASTSIDE SPORTS
REHABILITATION CLINICS

Acknowledgement of Receipt of
Privacy Practices Notice

I have been presented with a copy of Eastside Sports Rehabilitation Clinic's **Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

Consent to Leave Messages

Please complete and sign this form, indicating your preference.

I, _____, give Eastside Sports Rehab permission to:

- ✦ Leave a message, e-mail or text regarding my upcoming office visit, account information, or other pertinent information on my answering machine.

  YES / NO

- ✦ Leave a message, e-mail, or text with someone who answers the phone at my residence.

  YES / NO

Signed: _____ **Date:** _____

Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

PAYMENT POLICY:

As a courtesy to you, we will bill your primary, in-network insurance company. This treatment may or may not be a covered expense with your insurance policy. **Generally, insurance coverage is not 100% for physical therapy**.

Patients are required to know their own insurance policy coverage and limitations.

OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want my insurance billed for an official decision on payment. I understand that my health insurance company may deny payment for the services identified above, for reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance does make payment for services, **I will be responsible for any co-payment, deductible, or coinsurance that applies.**
☐ **OPTION 2.** I do not want to bill my insurance, or my insurance is out of network. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed and I cannot ask for my services to be billed to my out of network insurance.**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits are paid directly to the physical therapist. I am financially responsible for any balance due. I also authorize the physical therapist or insurance company to release any information required for this claim.

_____ _____

Signature of Patient (or patient's authorized representative) **Date**