19022 Aurora Ave N, Suite B
Shoreline, WA 98133
P: 206-988-8809
F: 866-329-2785

Patient Registration

(Please write legibly)

Today's Date:	Date of appointment:	Reason for treatment:	How did you hear about us?:

Full Name (First, Middle Initial, Last):	☐ Self-Pay ☐ Insurance ☐ Auto ☐ Work Comp

Date of Birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married	Minor: ☐ Yes ☐ No

Street Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:	Email:

Please Remind me of appointments via: ☐ Phone ☐ Email	Emergency Contact:	Phone #:	Relation:

Employer:	Occupation:

Employer Address:	City:	State:	Zip:

Primary Care Physician (*first, last*):	Phone #:	Location:	Have you had PT before? ☐ Yes ☐ No
Referring Physician (*first, last*):	Phone #:	Location:	When?

Primary Health Insurance:	Member #:	Group #:

Insured's Name:	Insured Date of Birth:	Relation:

Secondary Health Insurance:	Member #:	Group #:

Insured's Name:	Insured Date of Birth:	Relation:

Are you currently, or have you recently received Home Health services? ☐ Yes ☐ No	If yes are you still receiving treatment? ☐ Yes No
	If no, when were you discharged?

Auto/Accident/Worker Comp Insurance:	Claim#:	Date of Injury:

Adjuster Name:	Phone #:	Fax#:

Attorney Name:	Phone:	Fax#:

May we send you our newsletter? ☐ Yes ☐ No	

Health Status Form

Date: | Patient Name:

Present Complaint: | Date of Onset:

How did injury occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Do you have pain? ☐ Yes ☐ No | Rate Pain (0 no Pain – 10 high pain) At Best:_____ At Worst: _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No | If yes, when:

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan ☐ Ultrasound ☐ None ☐ Other _____

Describe your overall general health : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History

If yes, please provide details

High Cholesterol	☐ Yes	☐ No		Stroke	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No		Blood Clots	☐ Yes	☐ No	
Heart Problems	☐ Yes	☐ No		Pacemaker	☐ Yes	☐ No	
Seizures/Neurological	☐ Yes	☐ No		Cancer/Tumor	☐ Yes	☐ No	
Behavioral/Learning	☐ Yes	☐ No		Diabetes	☐ Yes	☐ No	
Anxiety/Depression	☐ Yes	☐ No		Hepatitis/HIV	☐ Yes	☐ No	
Genetic/Congenital	☐ Yes	☐ No		Asthma/COPD	☐ Yes	☐ No	
Are you pregnant?	☐ Yes	☐ No		Do You Smoke?	☐ Yes	☐ No	
Bone Joint Problems	☐ Yes	☐ No		If so, how much:			

Other (describe): _____

Significant Past Surgeries: _____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

Daily Activities

What does your job and/or home duties require? Check all that apply:

☐ Computer Work	☐ Standing	☐ Reaching	☐ Carrying
☐ Kneeling/Squatting	☐ Walking	☐ Climbing	☐ Lifting
☐ Repetitive Movement/Twisting	☐ Writing	☐ Pushing/Pulling	☐ Other _____

Section 1: Late Notice Policy

I agree to pay $50 for appointments that I missed or cancelled with less than 24 hours' notice. Notice means sending an email, a phone call, or leaving a voicemail during business hours.

INITIAL HERE

Section 2: Consent to Treatment

I hereby authorize the professional staff at Prevail Physical Therapy to examine and treat me with physical therapy for the Injury I have been referred here for or referred myself to.

INITIAL HERE

Section 3: HIPAA Regulations

I understand that Prevail Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of last bill collected.

INITIAL HERE

Section 4: Agreement for Direct Payment to Health Provider

Insurance Company/Companies(S):

I hereby instruct the above-named insurance company/companies to pay Prevail Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

INITIAL HERE

Section 5: Responsibility of Payment

It is the policy of Prevail Practices, PLLC (DBA Prevail Physical Therapy) to bill your primary (and secondary if applicable) insurance policies for you. Our services are typically covered by most health insurance policies. However, there are variances in benefits among insurance companies and among policies, and not all services will always be covered by every company. We will attempt to verify your insurance and explain your Physical Therapy benefits to you. We will also notify you of required payments as they apply. Copayments will be due at the time of each visit, and coinsurance charges will be billed to you after payment, or explanation of payment, has been made by your insurance company. Should prior authorization/referral be required by your insurance provider, it is ultimately your responsibility to ensure that the process has been initiated and completed. Any fees not covered by your insurance are your responsibility.

By initialing below, I hereby authorize my insurance company to pay directly to Prevail Practices, PLLC the amounts due for services rendered to me or to my dependent. I authorize the release of my medical records as needed to process my insurance claim, as well as with other healthcare providers if needed to allow better collaboration between providers. ***I understand that I am responsible for all unpaid charges owed to Prevail Physical Therapy for services rendered and/or equipment purchased.***

The benefits quoted to you by Prevail are not a guarantee of benefits. Our clinic provides a summary of them when we can, as a courtesy to the patient. We encourage you to call your insurance company to verify your specific outpatient physical therapy benefits.

INITIAL HERE

Benefit Summary

Patient Name:

Insurance Name(s): *In network: Yes / No*

Visit Limit: *Out of Network Benefits: Yes / No*

Deductible: *Met amount:*

Coinsurance: *Copayment:*

Prescription Required: Yes / No *Authorization Required: Yes/ No* *Ref Name/#*_____

Section 6: Signature and Date

I have read and understood Sections 1-5 and by initialing I have agreed to Sections 1-5.

_____

Patient Signature **Date**

_____

Printed Name **Date**

_____

Parent/Guardian Signature (*if* under 18) **Date**

_____

Parent/Guardian Printed Name **Date**