19022 Aurora Ave N Suite B
Shoreline, WA 98133
(206) 988-8809
(866) 329-2785
support@prevailpt.com
www.prevailpt.com

1. Patient Registration: Demographic Information

Today's Date _____ Date of Appointment _____ First Name _____

Middle Initial _____ Last Name _____ Gender ☐ Female ☐ Male

Street Address _____ City _____ State _____

Zip _____ Home Phone: _____ Mobile Phone: _____

Email Address: _____ Preferred mode of communication: ○ Home Phone ○ Mobile Phone ○ Email Address

May we leave a message? ○ Yes ○ No

Employer _____

Birthdate _____

2. Patient Registration: How Did You Hear About Us?

How did you learn about Prevail PT?
☐ Health Care Provider ☐ Internet Search
☐ Insurance Listing ☐ Personal Relationship
☐ Prior Patient ☐ Other

Elaborate (Name) : _____

3. Emergency Contact

Name: _____ Relationship: _____

Telephone #: _____ Alt. Phone: _____

4. Primary purpose for bike fit?

Patient Narrative _____

5. Do you have cycling related pain?

○ Yes
○ No

6. Describe the type of pain you experience (check all that apply)

- ☐ Sharp?
- ☐ Dull?
- ☐ Shooting?
- ☐ Burning?
- ☐ Stabbing?
- ☐ Tingling?
- ☐ Intermittent?
- ☐ Constant?
- ☐ Deep?
- ☐ Superficial?
- ☐ Numb?
- ☐ Other?

If other, specify:

_____

7. How severe is your pain: 0= no pain, 10= worst possible pain

At Best	At Worst	Currently
_____	_____	_____

8. What goal(s) do you have for your bike fit sessions? Check all that apply

- ☐ Decrease Pain/Improve Comfort
- ☐ Improve Strength
- ☐ Learn Further Injury Prevention
- ☐ Improve Performance
- ☐ Return to Sport
- ☐ Return to Bike Commute

9. Medical and Health History: How would you rate your physical health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

10. Medical conditions or concerns that may affect cycling ability or comfort

	Medical Conditions/injury
1	
2	
3	

11. Daily Activities/Occupation

_____

12. Overall Activity level

- ○ Sedentary
- ○ Light
- ○ Moderate
- ○ Active
- ○ Extremely Active

13. Prior Bike Fit(s):

	Bike make/model	When	Where
1			
2			
3			
4			

14. Bike Information

	Bike make/model	Type	Thru Axle? Y/N	Pedal Type	Shoe/Cleat corrections?

15. Cycling type/ level: Please describe your current / normal cycling type and how often you participate in each:

	Activity Type	Miles Per Week	Hours Per Week
Recreation			
Training			
Competition			
Commuting			

16. Other Activities: Please indicate the type and duration of exercise/sports/recreation:

	Activity	Miles Per Week	Hours Per Week
1			
2			
3			
4			

Late Notice Policy Section 1: 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)

_____
Signature

Consent To Treatment Section 2: I hereby consent to Bike fitting services, evaluation and bike or postural corrections by Prevail Practices, PLLC. By signing below I attest that all of the information that I have provided is true and accurate to the best of my knowledge.

_____ _____
Signature Date

HIPAA Regulations Section 3: 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 the last bill collected. (Initial)

_____
Signature

Responsibility of Payment Section 4: It is the policy of Prevail Practices, PLLC (DBA Prevail Physical Therapy) to bill your primary (and secondary if applicable) insurance policies for you when appropriate. 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. Bike fitting, unless in conjunction with Physical Therapy treatment of an injury, is typically not covered by insurance companies. As a courtesy, we may 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. Bike fitting service fees and any mechanical changes made to bike for fit adjustments are due at the time of service. 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)

_____

Signature

Signature and Date: I have read and understood Sections 1-4 and by initialing, I have agreed to Sections 1-4.
Full Signature: Parent/Guardian if under 18:

_____ _____

Signature Date