Burlington Physical Therapy
1186 S Burlington Blvd
Burlington, WA 98233
(360)757-9018 tele
(360)757-9019 fax

TODAY'S DATE_______________

Last Name___________________________________ First Name___________________________________ M.I.___________

Street Address ____ City_______________ State_____ Zip ____________

Home Phone ( )___________________ Cell Phone ( )____________________ Work Phone ( ) ________________

Emergency Contact: Name/Relation_____________________________________ Phone Number( )_________________

Your Social Security Number_________ - ____ - ___________ Your Date of Birth ________/_________/________

Sex: ☐Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

Referring Physician_____________________________________ Date of your NEXT appointment _______________________

Primary Care Physician__________________________________ Date of Surgery______________________________________

What is your occupation?____

Do you have an attorney? ☐ Yes ☐ No Attorney's Name ____________________Attorney's Phone#_______________

Work Status: ☐ Fulltime ☐Part-time ☐ Unemployed ☐ Retired
☐ Regular duty ☐ Light-duty ☐ On time-loss ☐ Student

Have you had any diagnostic tests? ☐ Yes ☐ No If yes, when and where?_____________________________________

Please circle all that apply: X-Ray CT Scan MRI Nerve Conduction Other__________________________

Have you received any Physical, Occupational or Speech Therapy services since January 1, of this year?
☐ Yes ☐ No

If yes, how many visits occurred and where were the services received? _______________________________________

How did you hear about Burlington PT?

My Doctor_____ Family Member______Friend________ Yellow Pages________Internet_______Other_______

Please provide the receptionist with your insurance card and photo ID so that we may copy it for billing accuracy

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Patient Name: ____ Date: ________________

Date of surgery/pain/problem began: (be as specific as possible) _____________________________________
Describe briefly how you were injured ____

Cause for Therapy (choose one):
- ☐Auto Accident
- ☐Fall
- ☐Employment Injury
- ☐Sporty Injury
- ☐Surgery
- ☐None of these

Pain Level *at best*:
None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Pain Level *at worst*:
None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Pain Level *right now*:
None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

My pain worsens with:
- ☐ Sitting
- ☐ Standing
- ☐ Laying down
- ☐ Walking
- ☐ Bending
- ☐ Going up stairs
- ☐ Going down stairs
- ☐ Sit to stand
- ☐ Voiding
- ☐ Coughing/Sneezing

Circle the ONE that BEST describes your pain:

burning sharp dull achy throbbing shooting numb/tingling

constant intermittent worse in AM worse in PM worse at night

Medical Conditions:
List all medications that you are taking: *(you may provide a list for us to copy if you choose)*
Prescriptions____

Over the Counter ____(for)______________________

Prior Surgeries/date ____

Check any medical conditions:

☐Diabetes Type 1	☐Asthma	☐Tuberculosis	☐ Allergies
☐Diabetes Type 2	☐High Blood Pressure	☐HIV/AIDS	
☐Arthritis _______________	☐Cancer _______________	☐Hepatitis (type)_________	

Are there any other medical issues we should be aware of? ____

Are you pregnant?	**N/A**	**Yes**	**No**
Do you have a pacemaker?		**Yes**	**No**

Medicare/Medicaid Clients: Height________ Weight_________

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CANCELLATION & NO SHOW POLICIES

CANCELLATION POLICY

Cancellations or changes to scheduled appointments **must be made 24 hours in advance** of your scheduled appointment in order for us to provide the highest quality of care for all of our patients.

We understand that things come up (specifically illness, transportation issues, hazardous conditions, or family emergencies), and we can accommodate unplanned emergency cancellations without 24 hours notice in these circumstances. However, if you cancel more than three (3) appointments within a 4-week time period, regardless of circumstances, a $50 fee will be issued per missed appointment. This fee is due at the time of your next appointment in order to be seen by the therapist. This **fee is not covered by your insurance** and it is your responsibility, no matter what type of insurance you have. By signing this form, you are agreeing to this policy.

NO-SHOW POLICY

A missed appointment impacts at least three people: 1) You, the patient, who misses a needed therapy session. 2) Another patient who could have been scheduled at your time. 3) The therapist/owner who must staff the clinic whether you show up or not.

If you fail to attend a scheduled appointment without notification or cancel within 24 hours of your scheduled appointment a $50 fee will be issued. It is our option to not reschedule you and/or to charge this fee. If you are allowed to reschedule, the fee will be due at the time of your next appointment in order to be seen by the therapist. This **fee is not covered by your insurance** and it is your responsibility, no matter what type of insurance you have. By signing this form, you are agreeing to this policy.

TIMELINESS

We make every effort to start your appointment at the scheduled time. Occasionally, we are delayed by an unexpected event with another patient. If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule. The therapist can choose to proceed with treatment, but your appointment will end at its scheduled time.

PATIENT CONSENT TO CANCELLATION & NO SHOW POLICY

- I acknowledge that I have read and understand and agree to the cancellation, no-show and timeliness policies as stated above.
- I understand that I am financially responsible for all charges related to cancelling or no-showing, and that **these charges are not covered by my insurance**, no matter what type of insurance I have.
- I understand that the parent/guardian of a minor will be responsible for payment.

Patient Signature____ Date______________

(Parent or guardian's signature if patient is under the age of 18)

Witness Signature ____Date______________

Policy as of November 1st, 2016

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FINANCIAL POLICY AND CONSENT & RELEASE

FINANCIAL POLICIES

We will gladly bill many insurance companies. We will do our best to verify that we can bill your insurance company. We will also make every attempt to obtain accurate information regarding your physical therapy benefits. If payment is denied by your insurance company after you have received treatment, you are responsible for the balance on your account. If we find that your insurance company does not cover physical therapy treatment, we will do our best to work out a solution for you so that you may receive the treatment needed.

Many insurance plans will require a co-payment. You are responsible for making co-pays at the time of your visit.

Payment must be made either at the time services are rendered or upon the receipt of your bill in the mail unless you contact us to make other arrangements. We are very willing to work out a payment schedule with you if your financial situation will not let you pay the full balance. If you do not contact us and your account is excessively past due, it will be turned over to collections.

If you have any questions about financial policies or need assistance with your bill or insurance, please call (360) 757-9018.

PATIENT CONSENT AND RELEASE

- I understand that Burlington Physical Therapy is not responsible for any personal belongings that I bring to the clinic.
- I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement or pending claims.
- I understand that the parent/guardian of a minor will be responsible for payment.
- I authorize Burlington Physical Therapy to release any necessary information requested by my insurance carrier, my employer's medical department, medical consultants, or my physician. I authorize Burlington Physical Therapy to obtain any diagnostic test results, including but not limited to X-ray, CT scan, and MRI imaging reports, pertaining to the current medical condition.
- I authorize payment directly to Burlington Physical Therapy for any benefits available under my insurance plan.
- I agree to pay co-payments (if applicable) for each visit at the time of service.
- I acknowledge that I have read and understand the financial policies as stated above.
- I hereby authorize and consent to treatment by Burlington Physical Therapy personnel.

Patient Signature____ Date_________________

(Parent or guardian's signature if patient is under the age of 18)

Please advise us immediately of any changes that may affect your billing

(change in insurance policy or claim number, address etc…)

Policy as of November 1st, 2016

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NOTICE OF PRIVACY PRACTICES

Effective Date: Jan 1, 2013

Burlington Physical Therapy
1186 S Burlington Blvd
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THIS NOTE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact the clinic at (360) 757-9018.

WHO WILL FOLLOW THIS NOTICE

This notice describes *Burlington Physical Therapy* and that of:
1) Any health care professional authorized to enter information into your chart. 2) All departments of the practice.
3) Any member of a volunteer group at our practice. 4) All employees, staff and other practice personnel.

All these entities follow the terms of this notice. In addition, these entities may share health information with each other for treatment, payment, of health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Washington State Law governs a patient's right of access to their healthcare information maintained by a healthcare provider. We are required by law to:
1) Make sure that your medical information is kept private. 2) Give a notice of our legal duties and privacy practices with respect to your medical information. 3) Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION AS FOLLOWS:

All of the ways we are permitted to use and disclose information will fall within one of the following categories.
For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other staff who are involved in taking care of you in our practice. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
For Payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party.
For Health Care Operations: We may use and disclose medical information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. We may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who our specific patients are.
To Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care.
For Health Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health related services or recommend possible treatment options or alternatives that may be of interest to you.
As Required By Law: We will disclose information about you when required to do so by federal, state, or local law.

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To Avert a Serious Threat to Health or Safety: Any disclosure of your health information would only be to someone who was able to help prevent a threat against the health or safety of any individual.

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
To Comply with Worker's Compensation Laws: If you make a worker's compensation claim, we may release information about you to anyone who is working with your claim.
For Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:
1) To prevent or control disease, injury or disability. 2) To report births or deaths. 3) To report child abuse or neglect. 4) To report reactions to medications or problems with products. 5) To notify people of recalls of products they may be using. 6) To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease. 7) To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make the disclosure if you agree or when required or authorized by law.
For Health Oversight Activities as Authorized by Law: These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.
For Law Enforcement: We may release your information for purposes such as when we receive a subpoena, court order, or other legal processes. We may also release your information if you are a victim of a crime or have been involved in a crime.
To Coroners, Medical Examiners, and Funeral Directors: We may release your medical information consistent with applicable laws allowing these people to carry out their duties.
To Authorized Federal Officials for National Security and Intelligence Activities: We may release your medical information about you for intelligence, counterintelligence, and other national security activities authorized by law.
To Authorized Federal Officials for Protective Services for the President and Others: We can disclose your information to authorized federal officials so they may provide protection to the President or any other authorized individuals.
To Correctional Institutions if you are in Jail or Prison: We may release your medical information as necessary for your health and the health and safety or others.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:
Right to Inspect and Copy: You have the right to inspect and copy information that may be used to make decisions about your care. Usually, this includes medical and billing records.
You must submit your request in writing to Burlington Physical Therapy. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. The cost of copying will be given to you upon your request of copies. You will receive your copy within 15 days of receipt of your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice.
Your request must be made to us in writing. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it in not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
1) Was not created by us, unless the party that created the information is no longer available to make the amendment. 2) Is not part of the medical information kept by this practice. 3) Is not part of the information, which you would be permitted to inspect and copy. 4) Is accurate and complete.
Any amendment made to your information will be disclosed to those with whom we disclose information as previously specified.

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You have the right to request a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.
You must submit your request in writing to Burlington Physical Therapy. Your request must state a time period, which may not be longer than seven years and may not include dates before Jan 1st, 2006. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.
Right to Request Restrictions: You have the right to restrict certain uses and discloses of your health and billing records.
You must deliver this request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. However, we are not required to agree with your request.
Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
You must make your request to us in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to Paper Copy of this Notice: You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, contact Burlington Physical Therapy at (360) 757-9018.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the accounts manager at (360) 757-9018. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by you written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I acknowledge receipt of a copy of the Burlington Physical Therapy “Notice of Privacy Practices.”

____ ____________________

Patient or Personal Representative Signature Date