



15811 Ambaum Blvd SW Suite 140, Burien WA 98166
tel. 206.327.9880 ~ fax. 206.327.9977 ~ inquiry@lakeburienpt.com ~ www.lakeburienpt.com

Welcome to Lake Burien Physical Therapy, Inc (LBPT). As a courtesy to you we bill your insurance company. In order to do so, please provide us with your insurance card and any additional information we need. **Your insurance coverage has been verified; however, this is not a guarantee of payment.** Please keep in mind that LBPT can only track your plan and prescription limits for services provided at LBPT. It is your responsibility to track services received from other practitioners in other offices. If you exceed your plan limits, you are responsible for payment of physical therapy services not covered by your plan.

Payment options: We accept personal checks, cash and credit cards. Insurance co-pays are due at the time of service. Applicable late fees must be paid before receiving any further treatment. **Bounced/returned checks will be assessed a \$25 fee.** If you do not have insurance, we require payment at each visit. **Any portion of your treatments not covered by your insurance becomes your responsibility, and is due within 30 days.** Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days. If you have any billing or insurance questions, please contact us and we will direct you to our billing staff. If you have any financial problems, please communicate them as soon as possible so that we may work out a mutually beneficial payment plan and not jeopardize your credit.

Workers Compensation: We bill your open and approved worker's compensation claim. **Please be advised that in the event your claim is denied, you are financially responsible for all charges.**

Motor Vehicle Accident: If you have Personal Injury Protection (PIP) we will bill your auto insurance. If your PIP is exhausted you may use your healthcare insurance to cover visits.

Supplies: Supplies are payable at the time of service. We will provide you with a receipt, so you may seek reimbursement from your insurance company.

Scheduling/ Attendance: Physical therapy is effective treatment if you are consistent with visits and your home exercise program. We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice to do so. **If you fail to attend a scheduled appointment, or do not give us 24-hour prior notification, you will be assessed a fee of \$50.** If you cancel or fail to show for 2 consecutive sessions, we will consider this a voluntary discharge from our care and remove any future appointments from our schedule. Arriving on time for your appointments is also critical to the optimal delivery of care. Chronic late arrivals are disruptive to the success of your care plan. Arriving more than 10 minutes late for 2 or more visits may result in discontinuing physical therapy. In the event that you are discharged, your referring provider or case manager will be notified of the reason for discharge from physical therapy.

Non-discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

Please be aware that you are financially responsible for services rendered. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent is responsible for the amount owing and all reasonable costs associated with the collection of this debt, including but not limited to, collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt.

Thank you for allowing LBPT the opportunity to serve you. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

- I understand that I need to provide 24 hours' notice before cancelling my appointment.
- I understand that I am subject to a fine of \$50 if I fail to provide proper notification of my cancellation.
- I understand that if I cancel late (less than 24 hours in advance) or miss two appointments that my therapy may be discontinued.
- I understand that Lake Burien Physical Therapy, Inc. does not accept third party payment and that I am responsible for paying any remaining balance.
- **FOR L&I PATIENTS:** I understand that reliably and consistently attending therapy sessions is essential to keeping my claim open. Lake Burien Physical Therapy is obligated to report any attendance issues to my claim manager.

Signature: _____

Date: _____

PATIENT REGISTRATION – PLEASE PRINT

Patient _____ Today's Date ____/____/____
Last name First name Middle initial

Address _____
City State Zip

E-mail _____
 *Appointment reminders are provided via e-mail.

Phone () _____ () _____ () _____
Home Work Mobile

SSN# _____ - _____ - _____ Birthdate ____/____/____ Age _____

Sex: Male Female Marital Status: Single Married Other

Employed: Full time Part time Student: Full time Part time
 Employer/School Name _____ Occupation _____

Employer's address _____
City State Zip

Patient's relationship to insured: Self Spouse Child Dependent

Emergency Contact _____

Relationship to patient _____

Emergency Phone () _____ () _____ () _____
Home Work Cell

IF INSURED IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION:

Name of insured: _____ Birthdate: ____/____/____
Last name First name Middle initial

Sex: Male Female

Insured's address _____
City State Zip

Phone () _____ () _____ () _____ SSN# _____
Home Work Cell

Employer _____

Employer's address _____
City State Zip



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PLEASE PROVIDE THE FRONT DESK WITH YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

Primary Insurance _____
ID number _____ **Group number** _____

Secondary Insurance _____
ID number _____ **Group number** _____

NOTE: We do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.

Name of referring physician: _____
First name Last name Designation

Physician address: _____
City State Zip

Physician phone number () _____ **Fax** () _____

IF THIS IS AN L&I CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Labor and Industry Claim Number: _____

Claim Manager: _____ **PHONE** () _____

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Name of Auto Insurance Company: _____

Adjuster/Claim Manager Name: _____

Claims Address: _____
Street City State Zip

Phone () _____ **Claim #:** _____

Patient's, Insured's, or authorized person's signature:

- I authorize payment of medical benefits to LAKE BURIEN PHYSICAL THERAPY, INC.
- I authorize the release of any medical records or other information necessary to process this claim.
- I hereby agree and consent to the plan of care proposed to me by the physical therapist to whom I have been referred. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse physical therapy services. I will ask for any information I want to have about my physical therapy care and will make my wishes known to the practitioner and/or staff. I understand that my insurance may deny payment based on non-covered services or medical necessity. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within 30 days of invoice. Payment plans are available.

Signed _____ **Date** ____/____/____

INSURANCE BENEFIT WORKSHEET

*****KEEP THIS WORKSHEET FOR YOUR RECORDS*****

THIS IS SOLELY FOR YOUR BENEFIT; THE FRONT DESK DOES NOT NEED THIS BACK. 😊

In order to assist you to fully understand your physical therapy coverage under your insurance plan, we have developed this questionnaire to be an aid for you to better understand your benefits. Though we also verify your benefits prior to your first appointment, the information we are quoted may differ from the information you receive. It is advisable that you know prior to your first appointment 1) your **CO-PAY** amount, and 2) whether your physical therapist is a **PREFERRED PROVIDER** for your plan. If your PT is not a preferred provider for your plan, you may not be eligible for in-network benefits.

- Insurance plan name or program name: _____
- Member ID number: _____ Group number: _____
- Customer Service phone number (w/area code): _____
- Name of customer service representative: _____
- Insurance claim address: _____
- Date eligibility began: _____
- Deductible: \$ _____ Co-pay: \$ _____ Co-insurance: \$ _____
- Maximum allowable benefit for physical therapy: \$ _____ # visits _____
- Remaining: \$ _____ # visits _____ for current year as of _____
- Is my physical therapist a **PREFERRED PROVIDER** for my plan? Yes No
- If your company is an HMO or PPO, and we are NOT a provider for the plan, what is the benefit coverage for Lake Burien Physical Therapy, Inc? (i.e., 60%, 80%, etc.) _____%
- Does this plan require a *referral* (NOTE: a referral and prescription are not one and the same) from the *primary care physician* to Lake Burien Physical Therapy, Inc. for payment of services? Yes No
- Does this plan require pre-authorization for physical therapy? Yes No



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PATIENT CONSENT AND RELEASE OF MEDICAL BENEFITS AUTHORIZATION

I hereby consent to evaluation and treatment by my Physical Therapist. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor and Industries claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I authorize Lake Burien Physical Therapy, Inc. to release any necessary information requested by my insurance carrier and authorize payment directly to Lake Burien Physical Therapy, Inc. for any benefits available under my insurance plan.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: provide and coordinate my treatment among health care providers who may be involved in that treatment directly; obtain payment from third-party payers for my health care services; and conduct normal health care operations such as quality assessment and improvement activities. I have been informed of Lake Burien Physical Therapy, Inc.'s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that Lake Burien Physical Therapy, Inc. has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that Lake Burien Physical Therapy, Inc, restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that Lake Burien Physical Therapy, Inc, is not required to agree to my requested restriction, but if Lake Burien Physical Therapy, Inc, does agree then Lake Burien Physical Therapy, Inc is bound to abide by such restrictions.

SIGNATURE: _____ DATE: _____

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGEMENT:

MOVEMENT MATTERS

INITIAL EVALUATION INTAKE FORM

- 1) Name: _____
Last First Middle
- 2) Date of Birth: ____/____/____
Month Day Year
- 3) Sex: ___ Male ___ Female
- 4) Are you: ___ Right-handed ___ Left-handed

SOCIAL HISTORY

- 5) Cultural/Religions: Any customs or religious beliefs or wishes that might affect care?

- 6) With whom do you live?
 ___ Alone
 ___ Spouse only
 ___ Spouse and children (# of children: ___) Ages of children living at home: _____
 ___ Children only (# of children: ___) Ages of children living at home: _____
 ___ Other relatives (not spouse or children)
 ___ Group setting
 ___ Personal care attendant
 ___ Other

- 7) Who referred you to us?
 ___ Physician ___ Physical Therapist ___ Claims Manager
 ___ Insurance Co. ___ Attorney ___ Yoga Instructor
 ___ Pilates Instructor ___ Personal Trainer ___ Other: _____

- 8) Employment/School:
 ___ Working full-time outside of home ___ Working part-time outside of home
 ___ Working full-time from home ___ Working part-time from home
 ___ Homemaker ___ Student ___ Retired ___ Unemployed
 Occupation: _____

SOCIAL/HEALTH HABITS

9) Smoking:

Do you currently smoke tobacco? Yes No
 If yes, how many packs per day? One More than one
 If you smoke cigars/pipes, how many? One a day More than one a day
 Have you smoked in the past? Yes No Year quit: _____

10) Alcohol:

How many days per week do you drink beer, wine, or other alcoholic beverages on average? 0 1 2 3 4 5 6+
 If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have on an average day? N/A 1 More than 1

11) Exercise:

Do you exercise beyond normal activities and chores? Yes No
 If yes, describe your exercise: _____
 On average, how many days per week do you exercise or do physical activities?
 1 2 3 4 5 6 7
 For how many minutes, on average? <20 20 30 40 >40

LIVING ENVIRONMENT

12) Does your home have...?

Stairs (no railing) Stairs (with railing) Ramps
 Elevator Uneven terrain Assistive devices (e.g., bathroom)
 Other obstacles: _____ Other: _____

13) Do you use...?

Cane Walker Motorized wheelchair Manual wheelchair
 Glasses Hearing aid Other: _____

14) Where do you live?

Private home/condo Private apartment Other: _____

GENERAL HEALTH STATUS

15) Please rate your health:

Excellent Good Fair Poor

16) Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member, etc.): ___ Yes ___ No

MEDICAL/SURGICAL HISTORY

17) Please check if you have ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken bones/fractures |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Parkinson disease | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Development or growth problems | <input type="checkbox"/> Heart problems | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Infectious disease (e.g., HIV, tuberculosis, hepatitis) | | |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Head injury | <input type="checkbox"/> Diabetes/high blood sugar |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Low blood sugar/hypoglycemia |
| <input type="checkbox"/> Repeated infections | | <input type="checkbox"/> Ulcer/stomach problems |
| <input type="checkbox"/> Other: _____ | | |

18) Within the past year, have you had any of the following symptoms?

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Dizziness or blackouts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Other: _____ | | |

19) Please list any surgeries you've had:

20) Please list any medications you are currently taking:

