Welcome to Lake Burien Physical Therapy, Inc (LBPT). We bill your insurance company as a courtesy to you. **We verify your insurance coverage; 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:** Bounced/returned checks will be assessed a $75 fee. Any portion of your treatments not covered by your insurance becomes your responsibility, and is due within 30 days of being billed. Interest will be charged at a rate of 1% per month (12% annually) for unpaid balances over thirty days. ______ (initial)

**Copays:** Your copay is due at time of service. Failure to pay copay for two consecutive treatment sessions will result in a discharge or hold in care until the balance owed is received. ______ (initial)

**Workers Compensation:** Please be advised that in the event your claim is denied, you are financially responsible for all charges. ______ (initial)

**Motor Vehicle Accident:** If your PIP is exhausted, you may use your healthcare insurance to cover visits. Please note that we do not work with lawyers and cannot accept payment for services from a law firm. ______ (initial)

**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. ______ (initial)

**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 require a 24-hour notice to do so. In this clinic we treat patients one-on-one for 1 hour sessions. As such we cannot easily fill a last minute cancellation. **If you fail to attend a scheduled appointment, or do not give us 24-hour prior notification, you will be assessed a fee in the amount of $135. ______ (initial).** 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. In the event that you are discharged, your referring provider or case manager will be notified of the reason for discharge from physical therapy. ______ (initial)

**Non-discrimination:** Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, gender identity 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. ______ (initial)
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 $135 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 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. _______ (initial)
PATIENT REGISTRATION – PLEASE PRINT

Patient _______________________________ Today’s Date _____/_____/_______
Last name   First name   Middle initial

Primary Insurance ____________________ GIVE COPY OF CARD TO FRONT DESK
Secondary Insurance __________________ GIVE COPY OF CARD TO FRONT DESK

Patient’s relationship to insured:  □ Self  □ Spouse  □ Partner  □ 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: _______________________________ Birth date: _____/_____/_______
Last name   First name   Middle initial
Sex:  □ Male  □ Female

Insured’s address ____________________________________________
City   State   Zip

Phone ( ) ___________ ( ) ___________ ( ) ___________
Home   Work   Cell

SSN# _______________________________

Employer _________________________________

Employer’s address _________________________________

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

ALL PATIENTS PLEASE SIGN THE FOLLOWING CONSENT:

Patients, 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 my claims.
• 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 / /
ACKNOWLEDGEMENT OF PRIVACY PRACTICES-HIPAA

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:
MEDICAL HISTORY

1) Name: ___________________________________________________________________
   Last  First  Middle

2) Date of Birth: ________/_______/_______
   Month  Day  Year

3) Sex:   ___ Male     ___ Female

4) Preferred pronoun: ___ He    ___ She    ___ They

5) Are you:     ___ Right-handed     ___ Left-handed

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

7) With whom do you live?
   ___ Alone
   ___ Spouse
   ___ Partner
   ___ Parent(s)
   ___ 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 ________________________________

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

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) ___ Elevator ___ Ramps  
___ 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
Please give us some details about this if you answered yes to the above question:
________________________________________________________________________
________________________________________________________________________

MEDICAL/SURGICAL HISTORY
17) Please check if you have ever had:
___ Arthritis ___ Osteoporosis ___ Broken bones/fractures
___ Multiple sclerosis ___ Blood disorders ___ Muscular dystrophy
___ Parkinson disease ___ Seizures/epilepsy ___ Circulation/vascular problems
___ Development or growth problems ___ Heart problems
18) Within the past year, have you had any of the following symptoms?

- Chest pain
- Heart palpitations
- Bowel problems
- Urinary problems
- Headaches
- Hearing problems
- Vision problems
- Other: ________________________________

- Cough
- Loss of appetite
- Weight loss/gain
- Fever/chills
- Loss of balance
- Difficulty walking
- Pain at night
- Other: ________________________________

- Difficulty sleeping
- Nausea/vomiting
- Shortness of breath
- Dizziness or blackouts
- Coordination problems
- Weakness in arms/legs
- Joint pain or swelling
- Other: ________________________________

19) Please list any surgeries you’ve had including dates:

________________________________________________________________________
________________________________________________________________________

20) Please list any medications you are currently taking:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

21) Please tell us why you are seeking physical therapy care:

________________________________________________________________________
________________________________________________________________________

22) Have you had any other care for this condition? If so, please list what type:

________________________________________________________________________

23) Please check all the ways that you have heard of us

- Email blast
- Burien Wellness Fair
- Facebook
- Burien Brat Trot
- Newsletter
- First Responder’s Conference
- Yelp
- Physician
- Other
- Friend/Colleague (please tell us who they are so that we may thank them)

________________________________________________________________________