PREMIER THERAPY
ASSOCIATES
PHYSICAL & HAND THERAPY

Intake Form

How did you hear about us? □ Health care provider □ Friend/Relative □ Website □ Other:

□ Male □ Female

First name _____ MI _____Last name _____

Address _____

City _____ State _____ Zip_____

Main Phone_____ Alternate phone_____

Birth Date _____Social Security # _____

Employer and job title: _____

(Retired? Homemaker? Student? Disabled?)

Email_____ (Used for confirmation of appointments only)

Emergency contact:

Name_____ Relationship_____

Phone_____

Billing information

☐ Insurance (we will make a copy of your insurance card). ☐ Self-pay (reduced rate of $100 per visit).
☐ Motor Vehicle- PIP ☐ State L&I ☐ Self-Insured L&I

If MVA or L&I claim, fill out the following:

Date of injury: _____ Claim number: _____

Insurance company name: _____ Phone: _____

Adjusters/case managers name: _____

Address: _____ City: _____ State: _____

Attorney (if applicable): _____ Phone: _____

Briefly describe how and where injury occurred: (e.g.; driving, on the job, at home, etc.):

_____

21827 76th Ave W, Suite 101, Edmonds, WA 98026
Phone: 425-582-0930
Fax: 425-582-7250

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Patient History Form

Past surgeries: (list & date) _____

_____

Current medications (prescription, over-the-counter): _____

_____

Past Medical History: Have you ever been told you have any of the following?

History of Cancer	Yes	No	Ulcers	Yes	No
Heart issues/ Angina/Chest Pain	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Hepatitis	Yes	No
Lung problems	Yes	No	Immunosuppression	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Stroke	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Diabetes	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other _____		

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	Headaches
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Night pain	
Dizziness	Nausea/vomiting	Changes in bowel or bladder function	

Sleep?

How have you been sleeping at night? Fine Disturbed Only with medication

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History of current issue:

Reason for visit? _____

Referring Physician_____ Last MD visit ____/____/____ Next MD visit ____/____/____

What date (approximately) did your present symptoms start? _____

How? (gradually, suddenly, injury, surgery)_____

How have your symptoms changed? getting better about the same getting worse

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other testing for this problem? (specify) _____

_____

What treatments have you received for this problem so far? _____

Aggravating Factors: What are **3 important activities** that you have difficulty with because of your current problem.

1) _____

2) _____

3) _____

Pain Scale:
On the scale below, circle the number which best represents the average level of pain over the last 48 hours:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain imaginable

Functional level:
Circle the number below which best represents your overall average level of function:

0	1	2	3	4	5	6	7	8	9	10
Cannot do anything									Able to do everything	

Goals:
What are your goals for therapy? _____

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Our financial policies:

We will bill your insurance as a courtesy to you. Please be aware that some, and perhaps all, of the services provided to you may be non-covered under your specific insurance plan. You will be responsible for all expenses excluded under your insurance plan. All co-payments are due at the time of service per your contract with your insurance. If you have no medical insurance, **private pay fees for Physical and Occupational Therapy services are discounted to $110 per session.** We are not contracted with all insurances. It is your responsibility to check your insurance plan for coverage. Regarding Department of Labor and Industries (state or self- insured) if your claim is denied or rejected, you are responsible for your expenses.

By signing below, I acknowledge and agree to receive and pay for all therapy services as outlined. I assume financial responsibility for any balance due, attorney or collection costs and for services rendered that are not covered by my insurance. I understand that my contact information will be made available to collection agencies should my account status become delinquent. I authorize the release of any health care information required for my claim to be processed. I further authorize my insurance benefits be paid directly to my health care provider at Premier Therapy Associates.

Signature: _____ Date : _____

Patient Privacy & HIPAA Consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the entire HIPAA (Health Insurance Portability and Accountability Act) NOTICE that is available to you at the front desk and on our websites for download.

I give permission for Premier Therapy Associates to discuss my medical information, including scheduling with:

List names: _____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ Date: _____

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We ask that you show us and your fellow patients consideration by calling at least 24 hours prior to your appointment if you need to cancel. This will allow us the opportunity to offer that appointment time to another patient.

Less than 24 hour notice policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. So without 24 hour notice:

- **After 3 cancellations with less than 24 hour notice** you will be charged $75. This charge cannot be billed to your insurance and this charge must be paid before we can put you back on the schedule.
- All remaining scheduled appointments will be cancelled and will be documented in your medical record.
- You will be allowed to make same-day appointments only (based on availability). You will no longer be allowed to schedule visits in advance.

No Show Policy

- After 3 no shows, no further appointments will be scheduled.

Thank you for showing our office and our patients with this courtesy. Signing below indicates you understand and agree with this policy.

Signature:_____ **Date:**_____

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PIP Policy

We do accept PIP (Personal Injury Protection automotive injury claims) but cannot take 3rd party. Any claims that become 3rd party will result in patient responsibility. In the event that your PIP becomes exhausted we will assume the right to bill you directly. At that time you may provide us with your personal healthcare insurance or assume personal responsibility for your balance at the discounted private pay rate of $110 per visit.

We also require an exact amount of your PIP to have in your chart. Unfortunately, the only information we are able to obtain from your claims manager is that you have a PIP – they will not release to us the current amount of your PIP.

You can call your claims manager and have them fax over the information to (425)582-7250. We do need something in writing by your second scheduled appointment.

Thank you for your assistance.

Signature:_____ **Date:**_____

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