



Intake Form

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

Male Female

First name _____ MI _____ Last name _____

Mailing 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 _____

Would you like appointment reminders? By phone. By email. No reminders.

Billing information

Insurance (we will make a copy of your insurance card). Self-pay (reduced rate of \$110 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.):



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



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. Therapy visit costs can vary by session depending upon the various service units billed by your treating therapist. Unfortunately, due to the diverse number of insurance plans and situational variables, we are unable to guarantee the accuracy of estimated out-of-pocket costs until claims are processed by your insurance company and received by us.

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:** _____



Less than 24 hour notice cancellation/ no-show policy

Please provide our office with **24-hour** notice to change or cancel an appointment. Patients who do not attend a scheduled appointment (no-show) or do not provide **24-hour** notice to change a scheduled appointment may be responsible for a \$75.00 service charge. **24-hour** notice allows us to offer that time to a wait-listed patient.

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

Signature: _____ **Date:** _____



PIP Policy

We do accept PIP (Personal Injury Protection automotive injury claims) but **cannot take 3rd party claims**. 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:** _____