RESILIENCE

A PHYSICAL THERAPY AND PILATES STUDIO

IF YOU WILL BE USING INSURANCE BENEFITS, PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM BY ASKING THE FOLLOWING QUESTIONS.
- PATIENTS ARE RESPONSIBLE FOR KNOWING THEIR BENEFIT INFORMATION -

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PATIENT'S FULL NAME: _____

INSURANCE COMPANY: _____ GROUP #: _____

POLICY ID # (WITH ANY LETTER PREFIX): _____

PRIMARY INSURED (IF DIFFERENT THAN SELF): _____

PRIMARY INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

DATE OF CALL: _____ TIME: _____ SPOKE TO: _____

YOUR PROVIDER IS: JOY BEATTY, NPI # 1437539335 PHONE # 206-280-9897

1. IS THE PHYSICAL THERAPY PROVIDER COVERED ON MY PLAN? Y / N

2. IS A REFERRAL REQUIRED? Y / N

3. IS PRE-AUTHORIZATION REQUIRED? Y / N

4. IS THERE A CO-PAYMENT THAT I (THE PATIENT) AM RESPONSIBLE FOR PER TREATMENT? Y / N IF YES, HOW MUCH IS IT? $ _____

5. IS THERE A CO-INSURANCE THAT I (THE PATIENT) AM RESPONSIBLE FOR? Y / N
   IF YES, WHAT PERCENTAGE OF THE VISIT IS COVERED:
   BY INSURANCE? _____ %
   BY PATIENT? _____ %

6. IS THERE A DEDUCTIBLE? Y / N
   IF YES, HOW MUCH IS THE DEDUCTIBLE? $ _____
   HOW MUCH HAS BEEN MET? $ _____

7. IS THERE A MAXIMUM YEARLY BENEFIT FOR PHYSICAL THERAPY? Y / N

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PERSONAL INFORMATION

FIRST NAME	LAST	MI	BIRTHDATE AGE
STREET			SOCIAL SECURITY #
CITY	STATE	ZIP	
DAY PHONE	EVENING PHONE	CELL PHONE	____Male ____Female
EMAIL			____Married/Partnered ____Single

In case of emergency, please notify:

NAME	RELATIONSHIP	CONTACT PHONE/S

EMPLOYMENT INFORMATION

OCCUPATION	____Full Time ____Part Time
COMPANY NAME	PHONE
STREET	
CITY STATE ZIP	STUDENT? SCHOOL:

INJURY INFORMATION

PRIMARY CARE PHYSICIAN			PHONE
LOCATION			DATE LAST SEEN
REFERRING PHYSICIAN			PHONE
LOCATION			DATE LAST SEEN
DIAGNOSIS			DATE: ONSET OF SYMPTOMS
PREVIOUS SURGERIES		DATE	LOCATION
PREVIOUS SURGERIES		DATE	LOCATION
MRI / CT SCAN	LOCATION	DATE	PHONE
X-RAYS	LOCATION	DATE	PHONE

HOW DID YOU HEAR ABOUT US?

____Doctor ____Family ____Friend ____Street Signs ____Website ____ Other:_____

PHYSICAL THERAPY BILLING POLICIES

In order to maximize our ability to see and help treat all of our patients, we have set the following policies. Thank you very much for your compliance and understanding.

LATE CANCELLATION POLICY

We have a 24 hour cancellation policy. If you cancel within 24 hours before an appointment or if you do not show at all, you will be billed $60, payable before your next appointment can take place. If you are late for an appointment, you will be charged $20 per 15 minutes, up to 30 minutes. If you are later than 30 minutes for an appointment, the appointment will need to be rescheduled and a $60 charge will be applied. Please note that insurance will not pay for late fees. If you no show/late cancel two times in a row, we will no longer schedule you.

CASH PAYMENT OR NO INSURANCE PATIENTS

For patients without insurance, or patients wishing to pay in full at time of service. We offer this service at a discounted rate The New Patient Evaluation is $120 and all following treatments at $90.00 a visit. We can also set up a payment plan if required.

INSURANCE

An insurance policy is a contract between you and your insurance company. Payment for Physical Therapy is your responsibility We do not accept responsibility for collecting an insurance claim or negotiating a disputed claim with your company. However, as a courtesy to you, we will assist you as follows:

ALL INSURANCE CLAIMS

We require your insurance information prior to your first visit to verify your outpatient Physical Therapy benefits Verification of benefits is NOT a guarantee of payment by your insurance company. We strongly encourage you to call your insurance carrier directly so that you may better understand your responsibility, if any, for treatment costs. Upon receipt of your insurance information, our billing service will submit your claim to your primary and secondary insurance carriers. Payments will be made directly to us. Your portion of the bill consists of (deductibles. co-payments, co-insurance, late cancel or no-show fees and any charges applied that are not met by your insurers) Payment is due within 10 days after receiving your statement. If you have questions please call us directly on 206-405-3560 for clarification.

INDUSTRIAL ACCIDENT (L&I) CLAIMS

We require your claim number and employer information. For accepted claims, your bill will be paid in full by L&I or Self-Insured employers. If your claim is denied or rejected, contact our billing service immediately to make other arrangements, as you will be responsible for your bill. If you miss 2 appointments we are obligated to notify your claims manager, and we will no longer place you on our schedule.

MOTOR VEHICLE ACCIDENT CLAIMS

Our service will bill the responsible insurance carrier based on the information you provide to us. Any unpaid balance is due within 10 days after you receive your statement. If the insurance carrier denies or excessively delays payment, you will be required to pay for treatment at time of service.

METHODS OF PAYMENT

We accept cash, personal checks, money orders, and all major credit cards. If you have questions about forms of payment, please ask our front desk. Checks returned for lack of funds will incur a $25 fee.

ACCOUNTS OVER 90 DAYS OLD

We will charge a Late Charge Fee of $30 for all accounts that are overdue by more than 90 days. This charge will be applied each month until the account is settled or payment plan agreed. Please call if your circumstances have changed and you may need to set up a payment plan to settle your account.

FINANCIAL POLICIES

In order to maximize our ability to see and help heal all of our patients, we have set policies in place regarding late arrivals, cancels & financial matters, and it is very important that you understand these policies.

RELEASE OF BENEFITS AND INFORMATION / ASSIGNMENT OF INTEREST

I authorize Resilience Physical Therapy and Pilates or my insurance company to release any information required for this claim. I consent to receive treatment as prescribed by my doctor. A copy of this authorization shall be as valid as the original.

SIGNED: _____ **DATED:** _____

CANCELLATION / NO SHOW POLICY

I have read the Cancellation Policy and understand that if I do not appear for an appointment, or if I cancel within 24 hours of an appointment, I will be charged a **$60** late cancellation fee, and I understand that this policy is rarely waived, even for illness and is strictly enforced. I also understand that late charges of **$20** per 15 minutes will apply, and that my insurance does not cover late charges. Charges from a Late Arrival or No Show will be paid for on my next visit and before any further treatment can take place.

INSURANCE PAYMENT

A claim will be submitted to my insurance company on my behalf. My portion of the bill is due within 30 days of invoice. In the event my insurance company denies payment, **I am fully and directly responsible for payment of my treatment.**
All **COPAYS** and **CO-INSURANCE** are due at the Time of Service. Time of service Co-Insurance payments will be 75% of my Co-Insurance percentage based on the average payment made by my health insurance; I understand that I will be billed for the balance of my Co-Insurance; or if there is a credit due me, the clinic will refund me promptly. Any care not covered by my insurance will require payment in full at the time of service.

TERMS OF PAYMENT

I am financially responsible for any balance due, within 30 days of invoice. I have read and understand the Resilience PT and Pilates Billing Policy. If, for any reason, my insurance company does not promptly remit payment, I understand Resilience PT and Pilates will not await payment but will require me to make payments on a current basis. The postponement by Resilience PT and Pilates of collections process on any unpaid fees shall not be considered a waiver of the right to collect the entire unpaid balance of fees owing. Returned check fee of $25 and a monthly late charge fee of $30 applied after 90 days.

I have read fully and understand the terms and conditions laid out above in the CANCELLATION/NO SHOW POLICY, INSURANCE PAYMENT and TERMS OF PAYMENT policies.

SIGNED: _____ **DATED:** _____

Thank you very much for your compliance and understanding. We truly value your patronage and improving health.

Name: _____ Date: _____ PT: _____

PRIVACY PRACTICES

NOTIFICATION OF PRIVACY PRACTICES: Acknowledgement of Receipt

We keep a record of the Physical Therapy services that we provide you. You have a right to see, copy, and correct that record. We will not disclose your record to others unless directed to do so by you or an authorized legal authority. Please contact the Privacy Officer for more information.

The Notice of Privacy Practices, mandated by Federal law details your rights regarding your medical information. It requires your signature as an acknowledgment of receipt. Please Pick up our Notice at the front desk when checking in for your first appointment.

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

SIGNED:_____ DATED:_____

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION

Please check all that apply:

_____ Please leave my appointment reminder calls at phone # _____

_____ You may leave a detailed message on voicemail at home # _____

_____ You may leave a detailed message on voicemail at work # _____

_____ You may leave a detailed message on my cell phone # _____

_____ You may leave a detailed message with my spouse/ significant other/ family member:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that I am responsible for notifying the clinic if any of the the contact numbers change.

SIGNED:_____ DATED:_____

SIGN-IN DOCUMENTATION

_____ My name can appear on the appointment sign-in sheet.

_____ I prefer not to have my name on the appointment sign-in sheet, and agree to stop at the front desk each appointment to request a private sign-in sheet.

SIGNED:_____ DATED:_____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year?

Two or more falls in the last year?

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Currently not taking any medications

Name:_____ Date:_____ PT Initials:_____

Date: Onset of symptoms:_____

Date: 1st seen physician:_____

Y N Have you had a prior injury to this area? Dates:_____

Y N Have you had previous therapy treatment for this?

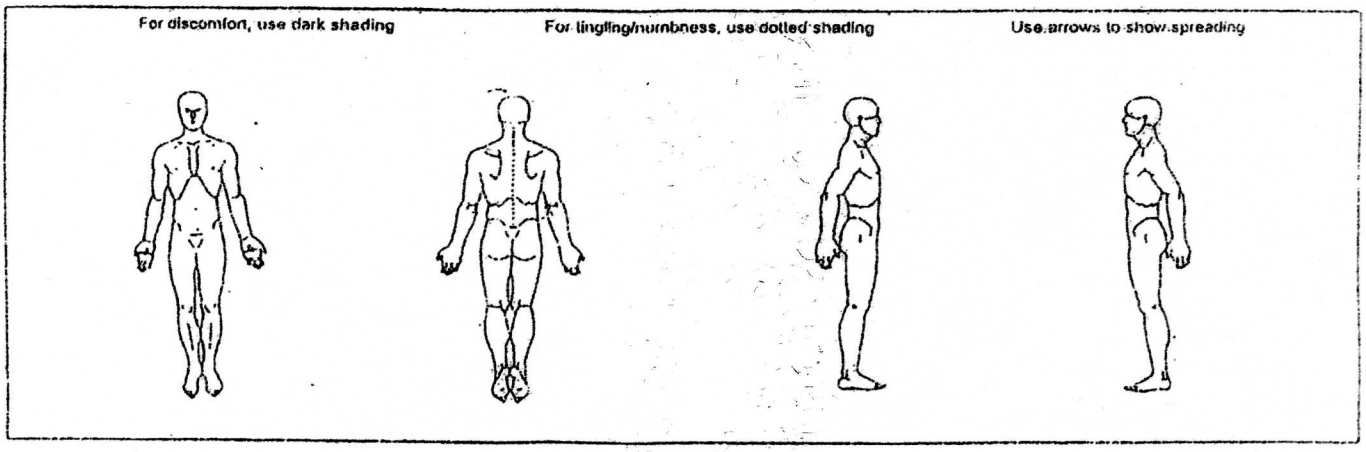
Describe:_____

_____

How did your symptoms begin?_____

_____

Indicate problem areas on the chart:



Y N In the evening, do your symptoms change? ___Increase ___Decrease

Y N Is it difficult to get to sleep? Y N Do your symptoms wake you up at night?

Describe your symptoms in the morning:_____

Describe your symptoms during the day:_____

Y N Do you have problems dressing, bathing, grooming?

Y N Is there anything you used to do that you are unable to do now?_____

What makes your condition better?_____

What makes your condition worse?_____

What goals do you wish to achieve from physical therapy?_____

Y N Do you normally exercise regularly? What exercise?_____

Y N Do you own or have access to exercise equipment? What equipment?_____

Y N Would you be willing to participate in a home exercise program?

Occupation:_____

Y N Are you working now? ___Full Time ___Part Time

What positions are you in while you are working: ___Standing ___Sitting ___Bending ___Lifting ___Walking ___Driving ___Other:_____

Are any of these positions painful?_____

What are your hobbies?_____

No pain

Pain as bad as it could possibly be

[1] If used as a graphic rating scale, a 10 cm baseline is recommended.
[2] A 10 cm baseline is recommended for VAS scales.