GREENLAKE
Sports Physical Therapy

office@greenlakesportspt.com
Phone: 206.524.5115 • Fax: 206.524.2456
408 NE 72nd St. • Seattle, WA 98115

PATIENT INFORMATION

Check one: ☐ ☐ Child (Under 16) Sex at birth: ☐ Male ☐ Female Current Gender Identity: ☐ Male ☐ Female ☐ Non-Binary

Adult Patient Name

First: MI: Last:

↳ Address ↳ City ↳ State ↳ Zip

↳ Mailing address for bills to be sent *(if different from above line)*

↳ Email Address

Date of Birth _____ Referring Physician_____

- Primary phone: (_____)_____ – - Secondary phone(____)_____

For your privacy and protection, please indicate which telephone number is acceptable to communicate medical information to you

How did you hear about GSPT? :_____

Emergency Contact

Name of emergency contact _____ Phone: _____ Relationship:_____

HIPAA

Notice Of Privacy Practices Acknowledgement

- We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record.
- We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.
- I acknowledge that Greenlake Sports Physical Therapy has made me aware of the HIPAA posted Notice of Privacy Practices and that a written detailed summary is available. I understand I may receive a copy of this complete summary upon request.

The information contained on this form is true and accurate to the best of my knowledge.

Signature of patient or guardian over 16 Date

Print name if signed on behalf of the patient Relationship Date

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OFFICE and BILLING INFORMATION

Welcome to our therapy clinic! Please review our office policies regarding insurance billing, interest on past due balance charges and late cancellation/missed appointment fees.

Insurance Benefits: While we make every effort to understand your insurance benefits, **a quote of benefits is not a guarantee of payment**. Your insurance will ultimately decide how much of your treatment will be covered when the claims are processed. You are financially responsible for all charges not covered by insurance, including deductible, copay, coinsurance, non-covered services and late cancellation fees.

It is your responsibility to respond to correspondence from your insurance company.

Please note that the number of visits covered or authorized by insurance may not equal the number of visits prescribed by your doctor.

Referral Requirements: If your insurance benefits specify that a referral is needed for physical therapy, **you are responsible for providing us such referral prior to your first visit**. If your insurance claims are denied due to not having a referral on file, you will be financially responsible for all charges.

Billing Procedures: We send out billing statements by mail once a month. Due to processing time, **please allow 6-8 weeks for your first statement**. You are responsible for keeping your address on file up to date so your statement can be delivered to you in a timely manner.

Copays are due at the time of service. If we fail to collect your copay at the time of service, the unpaid balance will be included in your monthly statement.

Private Pay: If you choose to pay out of pocket, we charge $120 per visit. Payment is due at the time of service. If we fail to collect payment at the time of service, the unpaid balance will be included in your monthly statement.

A charge will be applied at 1% per month on balances over 90 days past due.

Late Cancellations, Late Arrivals, Missed Appointments: We require 1 business day's notice to cancel or reschedule your appointment. Our business hours are Monday-Saturday, 7AM-6:15PM. You may contact us by phone or email. If you fail to arrive for your appointment and/or fail to contact us 1 business day before, a $50 missed appointment fee will be charged. I**nsurance does not pay for missed appointment fees**.

We reserve the right to reschedule your appointment if your are more than 10 minutes late. If you repeatedly arrive late or miss appointments, we reserve the right to only schedule same day appointments or to discontinue treatment.

Patient Authorization and Consent:

___I authorize Greenlake Sports Physical Therapy to bill my insurance and to be paid directly.

___I consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be deemed advisable while I am a patient at Greenlake Sports Physical Therapy.

___I understand and agree to the financial policies listed above.

_____

Signature of patient or guardian over 16 Date

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Medical Profile Questionnaire

Patient Name: _____ Date: _____

Describe your symptoms _____

_____

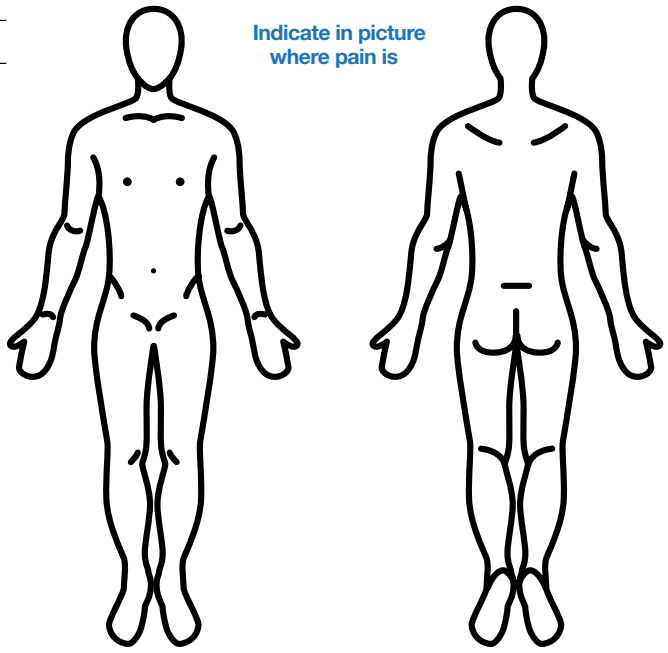
_____

_____

a. When did your symptoms start? _____

b. How did your symptoms start? _____

Indicate in picture where pain is



How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently 0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Shooting
☐ Dull ache ☐ Burning
☐ Numbness / Tingling

How are your symptoms changing?

☐ Getting better
☐ Not changing
☐ Getting worse

During the past 4 weeks:

a. Indicate the average intensity of your pain • *circle one*

None Moderate Unbearable

1 2 3 4 5 6 7 8 9 10

b. How much has pain interfered with your daily activites (including both work outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks how much of the time has your condition interfered with social activities?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

In general would you give say your overall health right now is…

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Who have you seen for your symptoms?

☐ No one ☐ Medical doctor ☐ Chiropractor ☐ Physical Therapist Other: _____

Have you had similar symptoms in the past? ☐ Yes ☐ No

What is your occupation?

☐ Professional / Executive ☐ Laborer ☐ Tradesperson ☐ White collar/Secretaria l ☐ Homemaker
☐ Student ☐ Retired Other: _____

If you are not retired, or a homemaker what is your current work status?

☐ Full time ☐ Part time ☐ Unemployed ☐ Off work ☐ Self Employed Other: _____

Patient Signature verifying statements are true: _____

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Referring Physician: _____

Date of last doctor's visit/exam:_____ Date of next visit/exam: _____

Family Physician/Internist: _____ Month/year last visit:_____

Check if you currently take any of the following MEDICATIONS:

☐ Steroids (cortisone)	☐ Anti-inflammatory	☐ Pain killers
☐ Muscle relaxants	☐ Anti-coagulants (blood thinners)	☐ Insulin (diabetes)
☐ Blood pressure meds	☐ Heart medication	Other:_____

I have a history of: *(check any that apply)*

☐ Cancer / tumors	☐ Dizziness	☐ Diabetes
☐ Heart trouble/Angina	☐ Hearing Problem	☐ Bruise easily
☐ Coronary Artery Disease	☐ Osteoporosis	☐ Arthritis
☐ Pacemaker/nitroglycerin patch	☐ Stroke	☐ Asthma
☐ Poor circulation	☐ Bladder problem	☐ Headaches
☐ High Blood Pressure	☐ Epilepsy/seizures	☐ Blackouts
☐ Recent & sudden weight changes	☐ Shortness of breath	☐ Smoking
☐ Chest, abdominal or pelvic surgery	☐ Frequent Falls	☐ Night sweats

For WOMEN: *(check if yes)*
- ☐ I have had a recent pelvic exam (pap)
- ☐ I am or may be PREGNANT
- ☐ I have had a recent mammogram or breast exam

For MEN: *(check if yes)*
- ☐ I have had a recent prostate exam

Have you had a concussion in the last 6 months? Yes or No *(circle one)* If yes, are you cleared for activity? Yes or No *(circle one)*

Name of healthcare professional who cleared you for activity:_____

Allergies: *(medications, food, tape, latex, beeswax, others)*
Please list reactions such as hives, rash, shock, difficulty breathing etc.: _____

_____

Surgery:_____

_____

Imaging, X-rays, MRI, CT: *(specify by name & date of studies & results if known)* _____

_____

_____
Signature of patient or guardian over 16 Date

_____
Print name if signed on behalf of the patient Relationship Date