



# CONSENT & RELEASE FORM

## **CANCELLATIONS AND NO-SHOWS**

Cancellations or changes must be made by the day prior to the scheduled appointment. If a patient fails to show for three (3) scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and no further appointments will be scheduled until we are notified by their physician.

## **TIMELINESS**

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected event with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time so other patients will not have to wait.

## **FINANCIAL POLICIES**

We are happy to bill many insurance companies. Please ask the front desk if you need to verify that we can bill your insurance company. We will do our best to verify whether outpatient physical therapy is covered by your insurance plan, and to determine the extent of coverage. If payment is denied by the insurance company after you have received treatment, you are responsible for the balance on your account. If we find that your insurance plan does not cover physical therapy, we will do our best to work out a solution with you to enable you to receive the treatment that you need.

We do bill secondary insurance plans, except for Medicare supplementary plans which are forwarded to the insurer by Medicare. You are responsible for anything that your insurance(s) don't cover.

Many insurance plans require a co-payment. Patients are responsible for their co-payments at the time of their visit.

Payment must be made either at the time services are rendered or upon the receipt of your bill in the mail unless you contact us to make other arrangements. We are very willing to work out a payment schedule with you if your financial situation will not let you pay the full balance. If you do not contact us and your account is seriously past due, it may be turned over to collections.

If you have any questions about financial policies or need assistance with your bill or insurance, please call and ask for the billing manager at 360-293-2417.

**Please advise us as soon as possible of any changes that may affect your billing, i.e., address, employment, new injury or insurance changes.**

## **PATIENT CONSENT AND RELEASE**

I understand that Coupeville Physical Therapy is not responsible for any personal belongings I bring to the clinic.

I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement, or pending claims. I understand that the parent/guardian of a minor will be responsible for payment.

I authorize Coupeville Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Coupeville Physical Therapy for any benefits available under my insurance plan. This information includes any photos taken during treatment.

I hereby consent to treatment by Coupeville Physical Therapy.

I acknowledge that I have read and understand the cancellation, no-show and financial policies as stated above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or guardian's signature if patient is under 18)



# Patient Registration Form

## General Patient Information

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
(Last) (First) (MI)

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Marital Status: M S D W P Smoker Non-Smoker

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

## For Medicare & Labor and Industries Patients

Have you received any Physical therapy, occupational therapy, or speech therapy services since January 1, 2008? 2010 ?  
 (Circle one) Yes No

If yes, When and where were these services received? \_\_\_\_\_

## Insurance Information

Primary Insurance Co: \_\_\_\_\_ Policy # \_\_\_\_\_

Insured Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_ Policy # \_\_\_\_\_

Insured Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

(MVA/L&I/Other) - Attorney's Name: \_\_\_\_\_ Attorney's Phone: \_\_\_\_\_

## Medical Information

List any medications you are taking: \_\_\_\_\_

List any allergies you may have: \_\_\_\_\_

List any prior surgeries: \_\_\_\_\_

Do you have any of the following?

	Now	Past		Now	Past
Dizziness			Chest Pain		
Stroke			Irregular Heartbeat		
Arthritis			High Blood Pressure		
Asthma			Cancer		
Diabetes			Shortness of Breath		
Pacemaker			Heart Disease		
TB			HIV		
HEP C			HEP B		



## Condition/Injury Information

Name: \_\_\_\_\_

Reason for seeking physical therapy services: \_\_\_\_\_

When did your injury/problem begin?      Within 2 weeks: \_\_\_\_\_      Date: \_\_\_\_\_      Other: \_\_\_\_\_

Is this visit because of an injury?     YES     NO

How did this injury occur?     Work     Auto Accident     Home     Recreation     Other

a. Have you ever been injured or suffered previous pains/problems in the area(s) before this injury?

YES     NO

If yes, when? \_\_\_\_\_

b. Have you had a recent X-ray, CT or MRI of the injured area?

YES

NO

When? \_\_\_\_\_

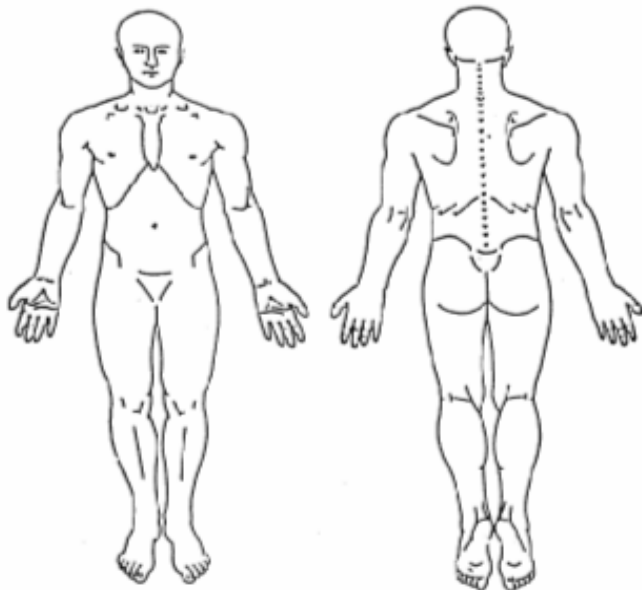
Where? \_\_\_\_\_

c. Did you recover from this injury?     YES

NO

From the list below, please check those activities that you are either unable to perform in a normal fashion or have difficulty performing because of your pain/problem.

	<u>Difficult</u>	<u>Unable</u>		<u>Difficult</u>	<u>Unable</u>
Sit	( )	( )	Housework	( )	( )
Stand	( )	( )	Yard Work	( )	( )
Walk	( )	( )	Twist	( )	( )
Push	( )	( )	Bend	( )	( )
Pull	( )	( )	Squat	( )	( )
Lift	( )	( )	Drive	( )	( )
Stretch	( )	( )	Ride in a Car	( )	( )
Climb	( )	( )			



Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain not related to your present injury or condition.

**/// : Stabbing**

**XXX : Burning**

**OOO : Pins & Needles**

**=== : Numbness**

**+++ : Achey**