DEER PARK PHYSICAL THERAPY

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

Welcome Patient!

All information must be filled out for the patient's insurance to be billed. Thank you.

Name _____ Date of Birth ____/____/____
SSN (for billing purposes): _____-_____-_____ Gender: ☐ Male ☐ Female ☐ Unspecified
Mailing Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____-_____-_____ Secondary Phone: _____-_____-_____
Email: _____
I would like a reminder via (check one): ☐ Phone call ☐ Text
I would like to receive that message on my (check one): ☐ Primary ☐ Secondary
Spouse/Parent/Guardian/Other: _____ Contact Phone Number: _____-_____-_____
Deer Park Physical Therapy is authorized to release information to the above named person: ☐ Yes ☐ No

---

Payment for treatment: ☐ Medical Insurance ☐ Private Pay ☐ Labor & Industries ☐ Other _____
Have you had any therapy treatments this year (OT, PT, ST, MT)? ☐ Yes ☐ No
If yes, how many treatments used? _____
Is this treatment part of a Workers' Compensation Claim (L&I) or Motor Vehicle Accident Claim (MVA): ☐ Yes ☐ No

---

Financial Responsibility Please Complete if: Financial responsibility is different than patient information above, OR is sponsored through TriCare, TriWest, or United Healthcare Military and Veterans.
Name _____ Date of Birth ____/____/____SSN (for billing purposes): _____-_____-_____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Authorization to Release Information:
Primary Care Physician: _____ Phone: _____-_____-_____
I authorize the following family members, friends, caregivers, etc. to be able to speak with Deer Park Physical Therapy on my behalf for any and all parts of my physical therapy treatments, scheduling, billing, and public program. This authorization will expire in 90 days.
_____ _____ _____

Emergency Contact - Local Relative or Friend NOT LIVING WITH YOU
Name _____ Relationship _____ Phone: _____-_____-_____

How did you learn about Deer Park Physical Therapy?

- ❏ Doctor Referral
- ❏ Returning Patient
- ❏ Website
- ❏ Google
- ❏ Social Media
- ❏ Newspaper
- ❏ Street Sign
- ❏ Phone Book
- ❏ Word of Mouth
- ❏ Friend/Relative
- ❏ Other_____

I have read and understand the Agreement of Terms on the reverse side of this document. I have been offered and understand the HIPAA packet: The notice of Privacy Practices. This packet is available in my Patient folder and at the **Deer Park Physical Therapy** office.

_____ _____/_____/_____
Patient Signature or Parent/Guardian Signature Date

DEER PARK PHYSICAL THERAPY

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

This is an agreement between **Deer Park Physical Therapy** and the patient named on this form. By executing this agreement, **you are agreeing to pay for all services and supplies that are received regardless of litigation, insurance reimbursement, pending workers' compensation, auto insurance settlement or other third-party settlement.**

Attendance: A plan is established between you, your Physical Therapist, and your Physician. Your scheduled appointment is set aside for you. If you arrive late your treatment will end at its scheduled time so the next patient will be seen at their scheduled time.

Financial Policy: Deer Park Physical Therapy will bill your primary insurance followed by your secondary insurance noted on the reverse page. As a courtesy to you, the billing office inquires about your benefits, however, benefits quoted are not a guarantee payment will be made by your insurance company. The insurance company makes the final determination of payment and eligibility. It is your responsibility to know your Outpatient Physical Therapy benefits and you assume full financial responsibility for any services or equipment received from **Deer Park Physical Therapy**. Parent/Guardian: You understand, if you are the parent/guardian, you are responsible for payment of services or supplies for the minor (under the age of 18) and must accompany the patient to their first appointment.

Any co-payments or co-insurance required by an insurance company must be paid at the time of service. If policy deductible is over $100.00, a $35.00 payment will be made each visit until the deductible has been satisfied. Co-insurance of 10% = $10.00; 20% = $20.00; 30% = $30.00; etc.

For questions or concerns, contact our billing specialist (509) 590-4206

Finance Charge: You understand finance charges of 1% per month, 12% per annum, may accrue on any unpaid balance over 60 days due and these charges will be included in the final bill.

Medical Supplies: Most medical supplies are not covered by your insurance. These must be purchased when dispensed. We accept cash, checks, and credit/debit cards.

Returned Check Fee: You agree to pay a fee of $25.00 for any check returned by your financial institution regardless of reason.

Referrals/Prescription/Authorization: If your insurance company requires a prescription for Physical Therapy, it is your obligation to provide a copy to **Deer Park Physical Therapy** for billing purposes. Should you choose to have Physical Therapy before the referral/prescription/authorization is obtained, you understand you are responsible for payment of your Therapy visit. **Self-Referral**: State laws provide **Direct Access** to licensed Physical Therapists without a physician's referral or prescription. You must check with your insurance plan to understand whether a physician order is required for direct access.

Workers' Compensation: Deer Park Physical Therapy requires approval/authorization by your workers' compensation carrier prior to your initial visit. If your claim is denied, payment shall be made by billing medical insurance and/or private pay. If your claim is in litigation, you must provide verification from your attorney and/or workers' compensation carrier of legal proceedings and monthly payments may be established.

Personal Injury/Motor Vehicle Accidents/Involvement of an Attorney: Deer Park Physical Therapy will verify a claim or lawsuit by the claim number, adjuster and phone number. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill PIP as primary insurance and will bill your private health insurance secondly. If your medical insurance policy denies the claim for any reason you are responsible for the full payment of your bill. A lien will be filed on any claim or lawsuit where your account has a balance owing, and you remain liable for the full payment of your bill. You understand the filing fees will be added to your account as your responsibility, and you must make monthly payments until settlement or other recovery pays your bill in full. You are not authorized to reduce the amount owed to us and you will instruct your legal representative accordingly.

Photo/Video: You give **Deer Park Physical Therapy** permission to take photographs/videos during your treatment sessions that may become part of your medical record.

Release of Information: You authorize **Deer Park Physical Therapy** to release to your insurance company/third party payer any information necessary for payment of your medical claims. You understand employers, or their authorized representatives may review any files of their own injured workers in connection with any workers' compensation pending claims. (RCW 51.28.070) You further authorize release of information for continuity of care and for quality improvement by **Deer Park Physical Therapy**.

Specific Authorization: You specifically authorize, unless expressly limited by you in writing to us, to release information related to medical diagnoses, procedures, testing and/or treatment that involve drugs and/or alcohol, sexually transmitted diseases, AIDS or HIV infection and/or mental health to your insurance company/third party payer. You understand you have the right to restrict release of information by giving us this information in writing.

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

Office and Billing Policies

Please read and sign each section

Scheduling Policies

We make every effort to accommodate your scheduling needs. We are constricted to the availability of Therapists and the office workload. **Please be aware that early morning and late afternoon appointments are in high demand. If possible, be sure to schedule at least a few weeks at a time if you have a strict timeline.**

Please be aware that we try our best to keep you with your Physical Therapy Team. However, there may be times where you may get shifted to another team member due to scheduling emergencies.

Cancellations and "No Shows": When you attend *all* your scheduled physical therapy appointments *without any Cancellations or No Shows* during your physical therapy series, **Deer Park Physical Therapy** will gift you with a Free Month Membership to our Fitness Center. We understand that incidents occur and there are times that you are unable to keep appointments. However, time is valuable for all of us and attendance of your Therapy sessions is essential for showing medical necessity to your Physician and insurance company. For this reason, we have a strong cancellation and "no show" policy.

As a courtesy to our staff and other patients, we ask that you provide 24-hour notice if you are unable to keep your scheduled appointment. If notice is given less than 24-hours in advance, it is considered a cancellation and stays on your chart as thus. If notice is given less than 12-hours in advance, it is considered a "no show." If you are more than 15 minutes late to your appointment, we reserve the right to mark your appointment as a "no show" and reschedule.

After 3 "no-show"/cancellation occurrences, we reserve the right to review your case and determine if a return to physician and/or discharge is appropriate.

_____ _____/_____/_____

Patient Signature or Parent/Guardian Signature Date

Billing Policies

We make every effort to obtain up-to-date insurance benefit information. However, this is not a guarantee of payment. As the patient, it is your responsibility to provide accurate information regarding your insurance coverage.

It is our policy that all patients must have a current referral from their attending physician when an insurance company is being billed.

Co-payments and co-insurances are expected when services are rendered (each visit). We accept most major credit cards and debit cards, checks, and cash.

Co-Pay: The dollar amount the policy holder is required to pay in full each visit.

Deductible: A *minimum* payment of $35.00 is required per visit if your deductible has *not* been met for the calendar year. This is to be applied to your account and the *remaining balance left by your insurance will be billed* to you each month.

Co-Insurance: Co-insurance refers to the percentage the policy holder is required to pay toward this medical bill. This percentage is collected as a co-pay per visit and is applied toward co-insurance obligations.

Medicare and Med-Advantage Plans: Please provide a copy of your Medicare card and supplemental insurance information. You will be billed for any remaining balance after your insurance plans have processed the charges. If you have a co-pay with your Med-Advantage Plan, you will need to pay this at the time of each service.

All Insurance: It is your responsibility to make sure a current referral has been obtained for your care with our office. If no referral has been obtained, your appointment may need to be rescheduled until you have a current referral unless your insurance states otherwise.

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

Billing Policies continued

Commercial / HMO Plans / Public Assistance Continued: Please bring a copy of your current insurance card so that we may bill for your visits. It is your responsibility to verify if we are contracted with your insurance carrier. Benefits may vary if we are out of network. It is your responsibility to verify if your insurance requires any authorizations for treatment and if there are limits on number of visits. You will receive a bill for any balance remaining after our charges have been processed by your insurance carrier and will be responsible for this balance. If you have any questions or need assistance, please ask for our billing department.

Workers' Compensation: Please bring your claim number, date of injury and current referral from your attending physician. Let us know if any prior physical therapy treatment exists on your claim. Your claim needs to be open and valid for the condition that we are seeing you for. If our charges are not accepted by workers' compensation, you will personally be billed and held responsible for these balances.

Motor Vehicle Accident (MVA) or litigation claims: Please provide a current referral from your attending physician. Let us know what treatments have taken place on your claim. Bring your auto insurance policy information regardless if you are the driver or passenger. This will include the claim number, phone number, MVA date, case manager and any other information available. If you have an attorney, we need their name and address for our records. If there is any balance remaining, you will be billed and held responsible to pay this balance.

Cash Pay Physical Therapy Visits: A $100 payment is required at the time of your first visit. If you need continuing treatment, you will need to make a $100 payment for each additional visit, required at the time of service. If payment is not made at Time of Service, the cash discount will not apply and you will be charged the full amount of your service.

"Cash Pay" services cannot be billed to your insurance. We (the provider) and you (the patient) cannot submit these services to your insurance company once treatment has begun. If you wish to use your insurance benefits at a later date, we will discharge the current case. We will then open a new case following your insurance guidelines.

Care for Child: A parent or legal guardian must accompany patients who are minors (under the age of 18) for the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy written above. The parent or legal guardian authorizes Deer Park Physical Therapy to administer Physical Therapy evaluations, manipulations, and treatments to the minor patient. The minor patient can attend subsequent visits unaccompanied by a parent or legal guardian.

Patient: I have read, understand, and agree to the above Office Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I understand it is my obligation to know what my insurance does and does not cover. It is also my responsibility to know if my insurance has deductible, co-insurance and/or co-pay requirements and that I am responsible for any remaining balance on my account. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf.

I have given complete and accurate information and agree to inform Deer Park Physical Therapy of any changes regarding my personal billing information or my insurance information.

_____ _____/_____/_____

Patient Signature or Parent/Guardian Signature Date

DEER PARK PHYSICAL THERAPY

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

Patient Medical History

Name _____ Age _____

Currently Employed? ☐ Yes ☐ No ☐ Other Occupation _____

Name of Employer: _____ State Located: _____

Current Symptoms

1. Is your current reason for treatment due to a recent surgery? ☐ Yes ☐ No
2. Describe your symptoms:

   _____

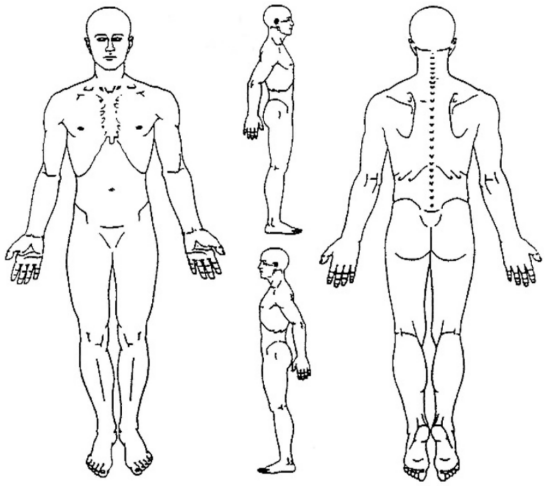
   _____

   When did your symptoms start? _____

   How did your symtoms begin? _____
3. How often do you experience your symptoms? ☐ Constant (76% - 100% of the time)

   ☐ Frequent (51% - 75% of the time ☐ Intermittent (26% - 50% of the time) ☐ Occasional (0% - 25% of the time)

   Are your symptoms: ☐ Sudden ☐ Gradual ☐ Persistent ☐ Other
4. On the diagram, shade in the areas where you feel pain/discomfort. Put an "X" on the area that hurts the most.



5. What best describes the nature of your symptoms?

   ☐ Sharp ☐ Shooting ☐ Dull ☐ Ache ☐ Burning ☐ Numb

   ☐ Tingling ☐ Loss of Balance ☐ Dizziness ☐ Blurry Vision
6. Have your symptoms been getting: ☐ Better ☐ Same ☐ Worse
7. During the last 4 weeks, indicate the average intensity of your symptoms/pain:

   None 0 1 2 3 4 5 6 7 8 9 10 Unbearable
8. During the last 24 hours, indicate the number that best corresponds to your symptom/pain level:

   None 0 1 2 3 4 5 6 7 8 9 10 Unbearable
9. How much have your symptoms interfered with your normal schedule, both at work/school and at home?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
10. Have you had these symptoms before? ☐ Yes ☐ No
11. Have you seen your primary physician for this? ☐ Yes ☐ No

---

Surgical History

Please list any surgeries including date:

Date: ___/___/___ Procedure _____ Date: ___/___/___ Procedure _____

Date: ___/___/___ Procedure _____ Date: ___/___/___ Procedure _____

Date: ___/___/___ Procedure _____ Date: ___/___/___ Procedure _____

DEER PARK PHYSICAL THERAPY

Deer Park Physical Therapy
707 S Park St | Deer Park, WA 99006
Phone: (509) 276-8811 | Fax: (866) 629-4801
DeerParkPT.com

Medical History

- ❑ Diabetes
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Hypertension
- ❑ Fibromyalgia
- ❑ Spondylosis
- ❑ Rheum. Arthritis
- ❑ Osteoarthritis
- ❑ Scoliosis
- ❑ Epilepsy
- ❑ Stroke
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Vasovagal Synd.
- ❑ Cancer
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Hemophilia
- ❑ Other_____

Social History

Do you smoke tobacco? ☐ Yes ☐ No ☐ In the past

Do you have a history of substance abuse? ☐ Yes ☐ No ☐ In the past

If yes, please describe: _____

Medications

Please list ALL prescription medications and their dosage (e.g. 300 mg 3x a day). You may also provide your own list.

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Medication: _____ Dose: _____ Reason: _____

Please list ALL supplements or over-the-counter medications you are taking:

_____

Please list any allergies or sensitivities to medications or chemicals:

_____

Treatment Restrictions

You must select one of the following:

It is important that you let us know if any of the following conditions currently apply to you. It is also important that you let us know if any of the following conditions become applicable during the course of your treatment.

- ❑ Pacemaker
- ❑ Electrical Implants
- ❑ Metal Implants
- ❑ Bleeding Disorders
- ❑ Taking Blood Thinners
- ❑ Pregnant
- ❑ Trying to get Pregnant
- ❑ Breastfeeding
- ❑ Hepatitis A/B/C
- ❑ Epileptic
- ❑ Faint Easily
- ❑ Food Allergies
- ❑ None of the above apply to me

_____ _____/_____/_____

Patient Signature or Parent/Guardian Signature Date