

Evening and Weekend Hours Available
8AM-8PM Monday-Friday • 10AM-3PM Saturday

Welcome to Greenwood Physical Therapy!

This packet contains your registration form, medical history and other documents for you to read and sign. If you are able to complete these forms prior to your arrival, it will help facilitate beginning your evaluation and treatment promptly.

Please bring to your first appointment:

- Your insurance card and driver's license
- Your doctor's written prescription or referral, if one is required for your policy
- The completed registration forms
- Any applicable co-pay
- Loose, comfortable clothing. Wear shorts if being treated for your lower back, hip, knee, ankle, or foot (women should wear a sports bra if being treated for a neck, mid-back, or shoulder injury).
- Secondary insurance information if you sustained a work injury or were involved in a motor vehicle accident

Parking is available on the street or in designated spaces labeled "Greenwood PT" in the first level garage just north of the clinic. You will need to walk out of the garage to enter the clinic, as there is no direct access from the garage.

Please check in 15 minutes early for your first visit and plan to spend between 45 to 60 minutes for your initial evaluation, which will include an interview and physical examination. Should you have any questions regarding your appointment, feel free to call our office at (206) 782-5789.

We look forward to serving you!

Sincerely,

Michael Osaki, PT, Director

Greenwood Physical Therapy Patient Registration

Please print neatly and write in ink

Today's Date: _____ Sex: Male Female Marital Status: Single Married Divorced Widowed

Patient Name: _____

Name you prefer to go by: _____ Date of Birth: _____

Address: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ E-mail Address: _____

Which phone number do you prefer for us to call? Home Cell Work

We send out daily email appointment reminders. Do you want a reminder call instead? Yes No

Employer: _____ Occupation: _____

EMERGENCY CONTACT (Name of local person who should be notified in case of emergency)

Name: _____ Phone: () _____ Relationship to Patient: _____

Release of Benefits and Information:

I authorize my insurance benefits to be paid directly to Greenwood Physical Therapy. I am responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I authorize Greenwood Physical Therapy 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.

Missed Appointment Policy:

It is very important for your recovery that you attend all your scheduled therapy treatments. We require 24 hour notice if you are unable to keep your appointment.

A \$50.00 fee may apply after a missed appointment if proper notice is not given.

- If you fail to show for two appointments, all remaining appointments will be removed from the schedule. If you wish to continue with your therapy, then you must call the day of to schedule an appointment.
- If two appointments are cancelled without sufficient notice, remaining appointments may be removed from the schedule. Future appointment scheduling may be limited to day of scheduling.

Signature of Patient or Guardian

Today's Date

Office Use:

Patient Information Entered in ApptPro: Initials: _____

Insurance Information Entered in Medisoft: Initials: _____



PATIENT INITIAL QUESTIONNAIRE

PLEASE PRINT _____
NAME

DATE

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

1. How did you find out about our clinic? _____

2. What are your symptoms? _____

Localize areas of pain or abnormal sensation on the body chart below (shade in where appropriate)

3. Which of the following best describes how your injury occurred? (**Check one**)

- | | | |
|---|---|---|
| <input type="checkbox"/> lifting | <input type="checkbox"/> degenerative process | <input type="checkbox"/> a dental appointment |
| <input type="checkbox"/> a MVA (car accident) | <input type="checkbox"/> during recreation/sports | <input type="checkbox"/> throwing |
| <input type="checkbox"/> a fall | <input type="checkbox"/> running | <input type="checkbox"/> unknown |
| <input type="checkbox"/> cumulative trauma | <input type="checkbox"/> a blow to the face | <input type="checkbox"/> other: _____ |

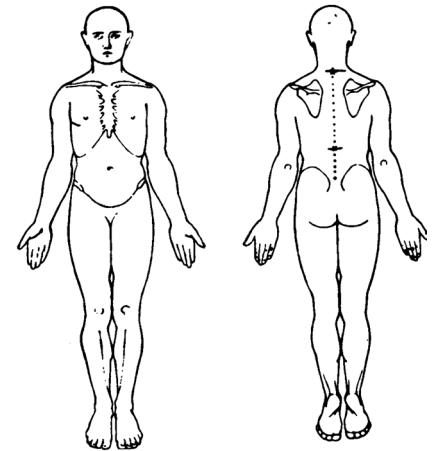
trauma _____ being hit by a ball

4. When did you first notice this episode of symptoms (month/date/year) and what was the mechanism of injury? Was it sudden or gradual?

Date of onset of symptoms/ or surgery date: _____

Onset was: (check one) Sudden Gradual N/A

Describe how your injury occurred:



5. **Since onset are your symptoms getting (check one):**

- better worse no change

6. Please indicate your pain level on a scale of 0 to 10 _____
(Zero = no pain, 10 = pain of maximum severity "emergency room pain")

7. Have you had similar symptoms in the past? If yes, when was the last episode?

None Previously YES date: _____

8. Nature of symptoms (check all that apply)

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> sharp | <input type="checkbox"/> aching | <input type="checkbox"/> tingling | <input type="checkbox"/> dull | <input type="checkbox"/> occasional |
| <input type="checkbox"/> numbness | <input type="checkbox"/> throbbing | <input type="checkbox"/> constant | <input type="checkbox"/> Other _____ | |

9. As the **DAY** progresses, do your symptoms:

- increase decrease stay the same

10. Does the pain wake you at night?

- yes no

If yes, how many times per night? _____

11. Are your symptoms worse in the morning, evening, or neither?

- morning evening neither

12. In what position do you sleep?

- right side left side stomach back

back / sides/ stomach other: _____

13. Have you experienced any of the following other medical symptoms (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> difficulty with bowel or bladder function | <input type="checkbox"/> unexplained weight change |
| <input type="checkbox"/> fever / chills | <input type="checkbox"/> night pain / sweats |
| <input type="checkbox"/> genital / anal area numbness | <input type="checkbox"/> malaise |
| <input type="checkbox"/> numbness in both arms and legs | <input type="checkbox"/> vision/ hearing problems |
| <input type="checkbox"/> dizziness or fainting attacks | |
| <input type="checkbox"/> generalized weakness | <input type="checkbox"/> none noted |

PLEASE PRINT: _____

NAME

14. Have you ever had an operation on the body region associated with your current symptoms? (Check one)

- No
- Yes, Date: _____

15. What aggravates your symptoms? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> sitting time: _____ | <input type="checkbox"/> reaching overhead | <input type="checkbox"/> coughing / sneezing |
| <input type="checkbox"/> going to / rising from sitting | <input type="checkbox"/> reaching out from body | <input type="checkbox"/> taking a deep breath |
| <input type="checkbox"/> standing | <input type="checkbox"/> reaching behind back | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> squatting | <input type="checkbox"/> reaching across body | <input type="checkbox"/> looking up overhead |
| <input type="checkbox"/> lying | <input type="checkbox"/> sustained bending | <input type="checkbox"/> swallowing |
| <input type="checkbox"/> walking | <input type="checkbox"/> recreation/sports including: _____ | <input type="checkbox"/> stress |
| <input type="checkbox"/> up/down stairs | <input type="checkbox"/> household activities: _____ | <input type="checkbox"/> Other _____ |
| # of flights _____ | | |
| <input type="checkbox"/> repetitive activities _____ | | |

16. What relieves your symptoms? (Check all that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> recreation/sports including: _____ | <input type="checkbox"/> whirlpool |
| <input type="checkbox"/> changing positions | | <input type="checkbox"/> medication |
| <input type="checkbox"/> standing | <input type="checkbox"/> rest | <input type="checkbox"/> nothing |
| <input type="checkbox"/> lying | <input type="checkbox"/> cold | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> walking | <input type="checkbox"/> heat | _____ |
| <input type="checkbox"/> stretching | <input type="checkbox"/> massage | _____ |
| <input type="checkbox"/> exercise | <input type="checkbox"/> traction | _____ |

17. What previous treatments have you had? (Check all that apply)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> none | <input type="checkbox"/> bracing / taping | <input type="checkbox"/> biofeedback |
| <input type="checkbox"/> medication (oral) | <input type="checkbox"/> traction | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> injection into the spine | <input type="checkbox"/> acupuncture |
| <input type="checkbox"/> joint manipulation by a Chiropractor or Osteopath | <input type="checkbox"/> injection into the skin / muscles | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> massage therapy | <input type="checkbox"/> surgery | |

18. Have you had any of the following:

- | | | |
|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> X-rays | <input type="checkbox"/> MRI | <input type="checkbox"/> Stress X-ray Test (Telos) |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> Other: _____ |

Results? _____

19. Are you currently working? Yes No Full Time Part Time Restricted Duty
Occupation (specific) _____

20. Do you exercise on a regular basis? Yes No

If yes, what type of exercise do you do? _____ Frequency _____

21. Do you have access to exercise/pool facilities? Yes No

22. Please list any activities you can't do now as a result of injury/ symptoms: _____

23. What goals would you like to achieve from therapy? _____

24. Please indicate if you have had or currently have the following medical conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> BREATHING DIFFICULTIES |
| <input type="checkbox"/> RECENT SURGERY(within year)
(PLEASE LIST) _____ | <input type="checkbox"/> BONE AND OR JOINT DISORDERS | |
| <input type="checkbox"/> HISTORY OF SEIZURES | <input type="checkbox"/> JOINT REPLACEMENT _____ | |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> UNREMARKABLE | <input type="checkbox"/> PREGNANT- (currently) |
| <input type="checkbox"/> MEDICATIONS (LIST) _____ | <input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> OTHER _____ |

Therapist use only

Aware of Diagnosis: YES NO **Previous Functional Level:** Independent all activities Assistance needed

Employment Status: Full time Part time Not working **Sports:** yes _____ # times per week no

Relevant Meds:

- Prescription ___pain ___NSAIDS ___Muscle Relaxants ___steroids ___anti depressant Other _____
- Non-prescription: ___asprin ___Tylenol/acetaminohen ___Advil/Motrin/ibuprofen None

Greenwood Physical Therapy Insurance Waiver

We will happily bill your insurance carrier (s) for your services. After your insurance processes your claims, you will receive a bill for all of the patient responsibility which includes deductibles and co-insurance. You will also receive a bill if any of the following occurs:

1. Treatment is not covered or deemed medically necessary by your insurance plan.
2. Your insurance benefits for these services have been exhausted.
3. Your insurance is pending and not guaranteed to be in effect at time of service.
4. Your insurance will not pay due to the nature or case of your injury.
5. Pre-authorization was not obtained.

Your portion of the bill is due within 10 days of receipt of the Greenwood PT statement. A re-billing charge of 1% per month is added to account balances over 60 days. If your account becomes 60 days past due and you are still requiring services, we require that you set up a payment plan to continue receiving treatment. If no payment is made, we reserve the right to discontinue services.

Physical therapy sessions range from \$100-\$300 depending on your individual needs, the services your doctor and physical therapist recommend for you, and the contracted rate we have with your particular insurance company. We are committed to doing all we can to provide the best outcome for you and to make sure your physical therapy experience is a good one. If you have any questions concerning your potential financial responsibility please speak with the receptionist, treating physical therapist, or your insurance company.

In the event of default of payment and/or failure to pay, you agree to pay all costs of collection including court costs and reasonable attorney fees to be determined by a court of law. If suit is commenced to enforce the terms of this Agreement, the Courts of the State of Washington and federal courts located in the State of Washington shall have personal jurisdiction over the patient, and the venue of suit, at the option of Greenwood Physical Therapy may be laid in King County, Washington.

By signing below, you agree that you understand and accept financial responsibility for services up to \$200 per visit.

Patient Signature

Date

Patient Name (Printed)

Notice of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPPA) and the state of Washington. This includes issues related to your treatment, payment, and our physical therapy operations. Your personal health information will never be otherwise given to anyone- even family members- without your consent. You, of course, may give consent authorization for us to disclose your information to anyone you chose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information:

We will only request personal information needed to provide our standard of quality of physical therapy services, implement payment activities, and conduct normal physical therapy operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your consent.

We may use and or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines.

Patient Rights:

You have a right to request copies of your healthcare information; to request copies in a variant of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above, all such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. Please let us know if you have any questions concerning your privacy rights and protection of your personal health information.

Greenwood Physical Therapy
8750 Greenwood Ave N Suite S-1
Seattle, WA 98103

Acknowledgment of Receipt of Statement of Privacy Practices:

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office Greenwood Physical Therapy. The Statement of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Greenwood Physical Therapy, PLLC reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional disclosure authority:

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family	Yes	No
Spouse Only	Yes	No
Other (please specify): _____	Yes	No

X _____	_____	_____
Signature	Date	Print Name

Office Use Only:

Record of Acknowledgement not obtained:

Provided prior to treatment? Yes No

Date Provided: _____

Reason for Denial _____ **Needed more time to review statement of Privacy Practices**

_____ **Unable to sign**

_____ **Other: Describe** _____