Phone GREENWOOD **206.782.5789**
Phone RAVENNA **206.388.2549**

fax 206.782.5794
www.greenwoodpt.com
Evening and Weekend Appointments Available

Welcome to GPT Physical Therapy!

This packet contains your registration form, medical history and other documents for you to read and sign. If you can 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 at *Greenwood* - Enter the first level garage just north of the clinic entrance and park in spaces labeled "GPT 24- hour reserved parking". You will need to walk out of the garage to enter the clinic, as there is no direct access from the garage. There is also free street parking available.

Parking at *Ravenna* - Enter the commercial garage from 34th Ave NE and park in any of the spaces that are labeled "GPT 24- hour reserved parking". There is also free street parking available.

Please check in 15 minutes early for your first visit and plan to spend between 45 to 60 minutes for your initial appointment, which will include evaluation and treatment. 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

GPT Physical Therapy Patient Registration

Please print neatly and write in ink

Date:_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Name: _____
Last *First* *MI*

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

Address: _____
Street *City* *Zip*

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

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

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

Ok to leave voicemail? Yes No

How would you prefer your appointment reminder? ☐ Call ☐ Email ☐ Text message, Cell carrier: ☐ AT&T ☐ T-Mobile ☐ Verizon ☐ _____

Employer:_____ Occupation: _____

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

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

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, or cancel two appointments without sufficient notice, remaining appointments may be removed from the schedule. Future appointment scheduling may be limited to same day scheduling.

Release of Benefits and Information:

I authorize my insurance benefits to be paid directly to GPT 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 GPT Physical Therapy or my insurance company to release any information required for these claims. I consent to receive treatment as prescribed by my doctor. A copy of this authorization shall be as valid as the original.

_____ _____
Signature of Patient (or Guardian) *Date*

Vestibular Questionnaire

Please print

_____
Name

_____
Date

1. How did you find out about our clinic? _____
2. What goals would you like to achieve in therapy? _____
3. What are your primary symptoms?
   - ☐ Imbalance
   - ☐ Trouble Walking
   - ☐ Staggering
   - ☐ Sense of leaning/tilt
   - ☐ Undulations (like on a boat)
   - ☐ Vertigo (spinning events)
   - ☐ Sense of floating
   - ☐ Nausea/queasiness
   - ☐ Visual conditions
   - ☐ Blurry vision
   - ☐ Jumping vision
   - ☐ Pain in ears
   - ☐ Ringing in ears
   - ☐ Hearing loss
   - ☐ Headache
   - ☐ Pain in neck
   - ☐ Lightheadedness
   - ☐ Disorientation
   - ☐ Poor memory / concentration / attention
   - ☐ Fatigue
   - ☐ Weakness
   - ☐ Other _____
4. How did the injury occur or what was the cause of symptoms (check one):
   - ☐ MVA (car accident)
   - ☐ a fall
   - ☐ trauma
   - ☐ incident during recreation/sport
   - ☐ an infection
   - ☐ after taking drugs/antibiotics
   - ☐ aging
   - ☐ unknown
   - ☐ other _____
5. Date of onset of symptoms / or surgery date: _____
6. Onset was: (check one) ☐ Sudden ☐ Gradual ☐ N/ A
7. Since onset are your symptoms getting (check one):
   ☐ better ☐ worse ☐ no change
8. Please indicate the severity of your symptoms on a scale of 0 to 10 _____
   (Zero = no symptoms, 10 = "worst symptoms ever imaginable")
9. Have you had similar symptoms in the past? If yes, when was the last episode?
   ☐ None Previously ☐ YES date: _____
10. Nature of symptoms (check all that apply)
    ☐ constant ☐ provoked by head movement or activity ☐ spontaneous
    ☐ other_____
11. How frequent are your symptoms?
    - ☐ How many times per day? _____
    - ☐ How many times per week? _____
12. How long do symptoms last?
    ☐ < 10 seconds ☐ > 60 seconds ☐ _____ hours ☐ other: _____
13. In what position do you sleep?
    ☐ right side ☐ left side ☐ stomach ☐ back ☐ back /sides/stomach ☐ other: _____

Name _____

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

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

15. Have you had an operation on the body region associated with your current symptoms? *(check one)*

☐ No ☐ Yes, date: _____

16. Have you had any falls *in the last week*?

☐ No ☐ Once ☐ More than once

17. What aggravates your symptoms?

- ☐ riding in elevators
- ☐ riding an escalator
- ☐ walking up or down stairs
- ☐ shopping in a crowded store
- ☐ shopping in a grocery store
- ☐ walking on a busy street
- ☐ reading
- ☐ driving a car
- ☐ making the bed
- ☐ bending over
- ☐ walking in the dark
- ☐ reaching up
- ☐ concentrating
- ☐ other: _____

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

- ☐ sitting
- ☐ changing positions
- ☐ standing
- ☐ lying
- ☐ walking
- ☐ stretching
- ☐ exercise
- ☐ recreation/sports including: _____
- ☐ rest
- ☐ cold
- ☐ heat
- ☐ massage
- ☐ traction
- ☐ whirlpool
- ☐ medication
- ☐ nothing
- ☐ other _____ _____

19. What previous treatments have you had for this condition? _____

_____

20. Have you had any imaging or vestibular tests? ☐ No ☐ Yes, results: _____

21. Are you currently working**?** ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Restricted Duty

Occupation (specific) _____

22. Do you exercise on a regular basis? ☐ Yes ☐ No

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

23. Please list any activities you cannot do now as a result of your injury / symptoms:

Primary limitation: _____ Secondary limitation: _____

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

- ☐ Unremarkable
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Recent surgery (within year) *List*_____
- ☐ History of Seizures
- ☐ Osteoporosis
- ☐ Heart disease
- ☐ Diabetes
- ☐ Bone or joint disorders
- ☐ Joint replacement *(Joint)* _____
- ☐ Latex allergy
- ☐ Depression / anxiety
- ☐ Pacemaker
- ☐ Breathing Difficulties
- ☐ Pregnant - (currently)
- ☐ Other: _____

25. What medications are you currently taking? _____

GPT Physical Therapy
Statement 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 (HIPAA) 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 authorizing 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 variety 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.

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 GPT Physical Therapy. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of health care office 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.

GPT 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

_____ _____

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 _____

GPT Physical Therapy
Financial Agreement

We will happily bill your insurance carrier(s) for your services. After your insurance processes your claims, you will receive a bill for any remaining 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-authorized was not approved.

Your portion of the bill is due within 10 days of receipt of the GPT Physical Therapy statement. Accounts are expected to be kept current unless an active payment plan is in place. If no payments are received within 90 days of a statement, an interest charge of 1% per month may be added to your account for each month until the account is paid in full.

Physical therapy sessions range from $120-$380 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 our office staff, treating physical therapist, or your insurance company.

By signing below, you agree that you understand and accept financial responsibility for services per the terms described above.

_____ _____

Patient Signature *Date*

_____

Patient Name (Printed)