



Phone GREENWOOD 206.782.5789

Phone RAVENNA 206.388.2549

fax 206.782.5794

[www.greenwoodpt.com](http://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 34<sup>th</sup> 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

*Greenwood* ♦ 8750 Greenwood Ave N, Suite S-1 ♦ Seattle, WA 98103

*Ravenna* ♦ 3290 NE 65th St, Unit 101 ♦ Seattle, WA 98115

# 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: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

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

Ok to leave voicemail? Yes No

- AT&T
- Sprint
- Verizon

How would you prefer your appointment reminder?  Call  Email  Text message\*, Cell carrier:  \_\_\_\_\_

\*Unfortunately, we are unable to send text message reminders to T-Mobile and Google carriers

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.*

\_\_\_\_\_  
By typing your name above, you agree to the above terms and conditions

\_\_\_\_\_  
Date



# PATIENT INITIAL QUESTIONNAIRE

(Please print)

Name \_\_\_\_\_

Date \_\_\_\_\_

This form contains a series of questions designed to help your Physical or Massage 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 goals would you like to achieve from therapy? \_\_\_\_\_
- 3. What are your symptoms? \_\_\_\_\_

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Lifting                | <input type="checkbox"/> Degenerative process     | <input type="checkbox"/> Being hit by a ball  |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> During recreation/sports | <input type="checkbox"/> A dental appointment |
| <input type="checkbox"/> A fall                 | <input type="checkbox"/> Running                  | <input type="checkbox"/> Unknown              |
| <input type="checkbox"/> Cumulative trauma      | <input type="checkbox"/> Throwing                 | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Trauma _____           | <input type="checkbox"/> A blow to the face       |   |

5. Describe how your symptoms began.

\_\_\_\_\_  
\_\_\_\_\_

6. Date of onset of symptoms or surgery date: \_\_\_\_\_

7. Onset was (check one)  Sudden  Gradual  n/a

8. Since onset, are your symptoms getting (check one)

- Better  Worse  No Change

9. Nature of symptoms (check all that apply)

- sharp  aching  tingling  dull  numbness  
 occasional  throbbing  constant  other \_\_\_\_\_

10. As the DAY progresses, do your symptoms

- increase  decrease  stay the same

11. Does the pain wake you at night?

- Yes  No

If yes, how many times per night? \_\_\_\_\_

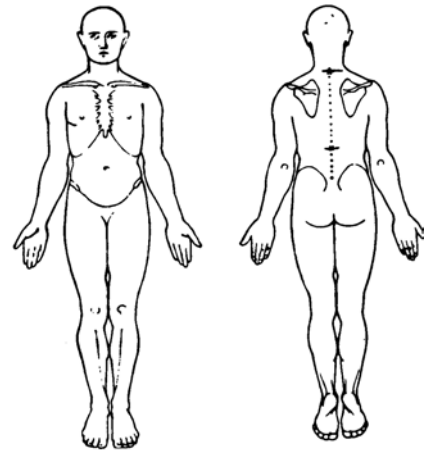
12. Are your symptoms worse in the morning, evening, or neither?

- morning  evening  neither

13. 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"/> up/down stairs                 | <input type="checkbox"/> recreation/sports      | <input type="checkbox"/> stress               |
| <input type="checkbox"/> repetitive activities _____    | <input type="checkbox"/> household activities   | <input type="checkbox"/> other _____          |

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



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

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

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

15. Please rate your pain on a scale of 0 to 10: \_\_\_\_\_ (Zero=no pain, 10=maximum pain)

16. Have you had similar symptoms in the past?

- None previously     Yes – date: \_\_\_\_\_

17. Have you had treatment for your current symptoms? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> physical therapy                                | <input type="checkbox"/> surgery           |
| <input type="checkbox"/> joint manipulation by Chiropractor or Osteopath | <input type="checkbox"/> biofeedback       |
| <input type="checkbox"/> massage therapy                                 | <input type="checkbox"/> TENS unit         |
| <input type="checkbox"/> bracing / taping                                | <input type="checkbox"/> Acupuncture       |
| <input type="checkbox"/> traction  | <input type="checkbox"/> Medication (oral) |
| <input type="checkbox"/> injection into the spine                        | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> injection into the skin/muscles                 |  |

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

Primary limitation: \_\_\_\_\_

Secondary limitation: \_\_\_\_\_

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

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Unremarkable  | <input type="checkbox"/> Heart disease                         | <input type="checkbox"/> Anxiety/Depression     |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Breathing difficulties |
| <input type="checkbox"/> High blood pressure                                 | <input type="checkbox"/> Bone and/or joint disorders           | <input type="checkbox"/> Pacemaker              |
| <input type="checkbox"/> Recent surgery (within year)<br>(Please list) _____ | <input type="checkbox"/> Joint replacement (type & side) _____ | <input type="checkbox"/> Pregnant (currently)   |
| <input type="checkbox"/> History of seizures                                 | <input type="checkbox"/> Latex allergy                         | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Osteoporosis  |  | _____   |

21. Current Medications: \_\_\_\_\_

22. Have you had any of the following tests for your current symptoms?

- X-rays     MRI     CT scan     Arthrogram     None     Other: \_\_\_\_\_
- Results? \_\_\_\_\_

23. Have you ever had an operation on the body region associated with your current symptoms?

- No     Yes: Date \_\_\_\_\_ Procedure: \_\_\_\_\_

24. Do you exercise on a regular basis?     No     Yes, type of exercise: \_\_\_\_\_ frequency \_\_\_\_\_

25. Are you currently working?     Yes     No     Full Time     Part Time     Restricted Duty

Occupation (specific) \_\_\_\_\_

## **GPT Physical Therapy Statement of Privacy Practices**

Our office is dedicated to protecting 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 of 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

\_\_\_\_\_  
*By typing your name above, you agree to the above terms and conditions*

\_\_\_\_\_  
*Date*

*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.

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*By typing your name above, you agree to the above terms and conditions*

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*Date*