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

Clear All

GPT Physical Therapy Patient Registration

Please print neatly and write in ink

Date:_____ ☐ 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

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

☐ AT&T
☐ Sprint
☐ Verizon
_ _____

*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*

Women's Health - Initial Questionnaire

Name: _____

Date: _____

1. How did you find out about our clinic? _____
2. What goals would you like to achieve in therapy? _____
3. Primary Complaint: _____

   Date of Onset:_____
4. Mechanism/Cause of Injury (check all that apply)

☐ After surgery	☐ Lifting
☐ Car accident	☐ Running
☐ Childbirth	☐ Trauma
☐ Degenerative process	☐ Unknown
☐ During recreation/sports	☐ Other _____
☐ Fall	_____

5. Symptom trend since onset:
   ☐ Better ☐ Worse ☐ No Change
6. Do pelvic symptoms wake you at night: ☐ No ☐ Yes, how many times: _____

   Is pain worse: ☐ in the morning ☐ in the evening ☐ neither
7. Nature of symptoms (check all that apply):

☐ Aching	☐ Hot/burning	☐ Splitting	☐ Constant
☐ Cramping	☐ Itching	☐ Stabbing	☐ Occasional
☐ Dull	☐ Sharp	☐ Tender	Other:_____
☐ Gnawing	☐ Shooting	☐ Throbbing	_____

8. What aggravates your symptoms (check all that apply):

☐ Coughing/sneezing	☐ Squatting	☐ Menstruation
☐ Going to/from sitting	☐ Standing	☐ Nothing
☐ Lying down	☐ Stress	☐ Exercise: _____
☐ Sexual activity	☐ Sustained bending	☐ Repetitive activities: _____
☐ Sitting	☐ Taking a deep breath	_____
☐ Sleeping	☐ Walking	☐ Other: _____

9. What relieves your symptoms (check all that apply):

☐ Cold	☐ Medication	☐ Stretching
☐ Exercise	☐ Rest	☐ Walking
☐ Heat	☐ Rising from sitting	☐ Nothing
☐ Lying down	☐ Sitting	☐ Other: _____
☐ Massage	☐ Standing	

10. Please indicate your pain level on a scale of 0-10 (0 = no pain, 10 = max pain): _____

Name _____

11. What previous treatment have you had (check all that apply):

☐ Biofeedback	☐ Joint manipulations by DC or Osteopath	☐ Surgery
☐ Dietary changes	☐ Laser	☐ TENS unit
☐ Electrical stimulation	☐ Overnight hospitalization	☐ Ultrasound
☐ Injection into skin/muscles	☐ Physical therapy	☐ None
☐ Injection into spine	☐ Pelvic floor exercises	☐ Other: _____ _____

12. Activities restricted because of symptoms (check all that apply):

☐ Caregiving	☐ Shopping	☐ Walking
☐ Housework	☐ Sleep	☐ Work activities
☐ Laughing	☐ Sneezing/coughing	☐ Yard work
☐ Lifting	☐ Social activities	☐ Other:_____
☐ Sexual activity	☐ Sports/recreation	_____

13. Sexually Active: ☐ Yes ☐ No
Pain/problems with sexual activity include: _____

Past Medical History

14. Previous exams/tests:
Last Pelvic Exam (date): _____ Last Urinalysis (date): _____
Other Special Tests (date, type, results): _____

15. Sexually transmitted Diseases:
☐ No History ☐ Yes (type) _____

16. Pregnant or attempting pregnancy: ☐ No ☐ Yes (due date): _____
Other: _____

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

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

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

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

19. Current Medication (including medications for Thyroid, Hormone Therapy, Migraine HA, Contraception):
_____

20. Have you ever had an operation on the body region associated with your current symptoms?
☐ No ☐ Yes, Date, type: _____

21. Please list any other surgical procedures:
Type _____ Date _____
Type _____ Date _____
Type _____ Date _____

Name _____

Women's Health Questionnaire - Bowel and Bladder function only

(If you are not having bowel or bladder issues, you may skip this page)

1. Symptoms (check all that apply):

- ☐ Difficulty initiating stream/bowel movement
- ☐ No perception of bladder fullness
- ☐ Weak, slow or intermittent stream urine
- ☐ Frequent toileting to avoid problems
- ☐ Dribbling after stream ends
- ☐ Pain/burning during urination/defecation
- ☐ Blood in stool/urine
- ☐ None

2. Frequency and Occurrence of Leakage: _____

3. Severity of Incontinence/leakage:

☐ None ☐ Few drops ☐ Wet underwear ☐ Other: _____

4. Position or activity with leakage (check all that apply):

- ☐ No leakage
- ☐ Sitting
- ☐ Standing
- ☐ Lying down
- ☐ Changing positions
- ☐ Coughing
- ☐ Laughing
- ☐ Sneezing
- ☐ Running
- ☐ Walking
- ☐ On way to toilet
- ☐ When constipated
- ☐ Sexual act
- ☐ Strong urge
- ☐ Other: _____ _____

5. Prolapse or falling out feeling (check all that apply):

- ☐ Never
- ☐ Occasionally with menses
- ☐ Pressure at the end of day
- ☐ Pressure with straining
- ☐ Pressure with standing
- ☐ Perineal pressure all day
- ☐ Other: _____

6. Ability to delay need to eliminate:

A. Bowel
- ☐ Indefinitely
- ☐ One hour or more
- ☐ One half hour
- ☐ 15 minutes
- ☐ Less than 10 minutes
- ☐ 1-2 minutes
- ☐ Other: _____

B. Bladder
- ☐ Indefinitely
- ☐ One hour or more
- ☐ One half hour
- ☐ 15 minutes
- ☐ Less than 10 minutes
- ☐ 1-2 minutes
- ☐ Other: _____

7. Ability to stop Urine flow

- ☐ Can stop completely
- ☐ Can maintain a deflection of the stream
- ☐ Can partially deflect the urine stream
- ☐ Unable to deflect or slow the stream
- ☐ Other: _____ _____

8. Number of pads/leakage protection worn per day: _____

9. Type of protection worn:

- ☐ None
- ☐ Tissue/paper towel
- ☐ Panty liner
- ☐ Medium flow pad
- ☐ Heavy flow pad
- ☐ Specialty pad/protective garment

10. Number of bowel or urine leakages per 24-hour period: _____

11. Frequency of urination: daytime _____ nighttime _____

12. How many bowel movements per week: _____

13. Fluid intake: How many 8 oz glasses of fluid per day: _____
How many beverages containing caffeine per day: _____

14. Any other concerns: _____

_____

Name _____

Women's Health Questionnaire - Postpartum only

(If you have delivered a baby in the last two years, please complete this page)

PREGNANCY INFORMATION

Pre-pregnancy weight _____ Weight gained during pregnancy _____

Did you exercise during your pregnancy? If yes, what type of exercise did you do?

_____

How many times per week? _____ How long was an average workout? _____

Would you consider yourself hypermobile (i.e. loose-jointed) generally? ☐ Yes ☐ No

Did you experience back or pelvic girdle pain during your pregnancy? ☐ Yes ☐ No

Did you seek any health care for this and, if so, from whom (Dr, PT, massage, chiro) _____

Did you experience urinary incontinence during your pregnancy? ☐ Yes ☐ No

Did you seek any health care for this and, if so, from whom (Dr, PT, massage, chiro) _____

BIRTH EXPERIENCE INFORMATION

How many children do you have? _____ How old are they now? _____

Type of birth for each: vaginal or C-section _____

For each birth if vaginal, how long was the pushing phase? _____

If C-section, was it ☐ planned or ☐ emergency?

Did you have an episiotomy or tear with any of your births? ☐ Yes ☐ No

Did you have any other complications from childbirth? _____

POSTPARTUM HEALTH CHECK -- Check the following that apply to you now:

☐ Do you have a diastasis (abdominal separation)?
☐ Non-resolving hemorrhoids
☐ Constipation or difficult with evacuation of the bowel (straining)
☐ Urinary incontinence with cough, sneeze
☐ Urgency (feeling a need to go (bladder or bowel) right now but can hold it until you reach the toilet
☐ Urgency and incontinence (can't quite make it to the toilet without leaking)
☐ Back pain and/or pelvic girdle pain
☐ Pain in other joints of the lower extremity
☐ Clicking in your pubic symphysis or sacroiliac joints (front or back of pelvis)
☐ Difficulty breathing, feeling short of breath
☐ Painful intercourse

Are you currently exercising? If yes, describe type, frequency and duration of workouts.

_____

_____

LIFESTYLE FACTORS

Are you breastfeeding? ☐ Yes ☐ No How often? _____

How much sleep are you getting each night? _____

What are your daily responsibilities? (cooking, cleaning, working, errands, infant care, etc)

_____

_____

_____

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

_____ _____

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.

_____ _____

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

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Consent for Pelvic Floor Evaluation and Treatment

I understand that I have been referred to GPT Physical Therapy for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunction may include bladder symptoms, bowel dysfunction, pain in or near the pelvis, and sexual dysfunction. I understand that the evaluation of my condition may include an internal pelvic floor muscle assessment. This assessment is used to determine pelvic floor muscle strength and length, scar mobility, and the source of the pain.

I am aware that the assessment and treatment may include observation, palpation, and mobilization of the structures in the pelvic floor region, exercise instruction, and biofeedback. Biofeedback may include the placement of electrodes internally or externally at locations around the pelvic floor region. I agree to ask questions until I am fully satisfied that I understand the assessment and treatment program. I also understand that my therapist will provide me with alternative treatment options if I am not comfortable with the internal pelvic floor muscle assessment or treatment.

I have been informed that all procedures will be carried out by a skilled physical therapist with specialized training in pelvic floor rehabilitation. I understand that I may invite someone to accompany me during my appointment if desired.

_____ _____

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

_____

Signature of parent/guardian (if applicable)- By typing your name above, you agree to the above terms and conditions