



Appt. Date

PATIENT INFORMATION					
Last Name	First	MI	Date of Birth	Social Security Number	Male Female
Home Address		City	State	Zip Code	Home Phone ()
Marital Status Single Married Other		Have you been treated at this or any other physical therapy clinic before? If yes, where?			
Employment Status Employed Full Time Student Part Time Student N/A			Employer Name/School Name		Title/Position
Work Address		City	State	Zip Code	Work Phone ()
E-Mail Address					

REFERRING PHYSICIAN INFORMATION				
Last Name	First	MI	Address	Telephone ()

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION				
Last Name		First		MI
Address		City	State	Postal Code
Home Phone ()		Work Phone ()		
Relationship Spouse Parent Guardian		Parent or Guardian E-Mail Address		

REASON FOR TODAY'S VISIT				
Is this injury/condition related to your ...				
Job Yes No		Car Yes No		Home Yes No
				Other Accident Yes No
Please indicate the date of accident/injury:			Please indicate the date of illness (1 st symptom):	
Please provide name of insurance adjuster or contact:				Telephone ()
Please describe injury/accident/illness:				

RESPONSIBLE PARTY STATEMENT	
As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.	
Responsible Party Signature	Date

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name		Identification Number		Group Number	
Address	City	State	Zip Code	Telephone ()	
Policyholder (if other than patient)		Male		Female	Date of Birth
Social Security Number (of policyholder)		Telephone (of policyholder) ()		Relationship to Patient	
Employer (of policyholder)					

SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name		Identification Number		Group Number	
Address	City	State	Zip Code	Telephone ()	
Policyholder (if other than patient)		Male		Female	Date of Birth
Social Security Number (of policyholder)		Telephone (of policyholder) ()		Relationship to Patient	
Employer (of policyholder)					

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Action Reaction Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Action Reaction Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Authorized Signature		Date
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Welcome to Action Reaction Physical Therapy, Inc.

Insurance Information: We will bill your medical insurance company. On your first visit to our office, please provide us with your insurance card and any additional information we may need for your treatment. It is recommended that you call your insurance company to verify your therapy coverage. It is your responsibility to know your policy benefits and limitations. Our billing office is can answer questions you may have regarding our billing procedures by phone.

Motor Vehicle Insurance: We will bill your open MVA claim. It is recommended that you call your insurance company to verify the amount of coverage and how much is available on your claim. In the event that coverage for services on your plan is for "reasonable and customary", you will be responsible for the amount not paid by the insurance.

Third Party Insurance: In the event your Motor Vehicle Accident involves third party insurance, you will be charged a \$50 Lien Filing Fee. This fee will cover the cost of filing the lien, renewing and releasing the lien once a settlement and payment have been received.

Workers Compensation Claims: We will bill your open, approved workers compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

Payment Options: We accept personal checks, debits, cash, Visa, MasterCard, Discover, and American Express. Insurance co-payments are due on each visit. For all payments made in the clinic, a written receipt will be given to you. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over 30 days old. Additionally, a \$27.00 fee will be charged to the patient for each incident that a check is returned to us with insufficient funds.

Supplies: We will bill your insurance for any DME (Durable Medical Equipment) that is covered by your insurance plan. Non-covered supplies are due at the time of service.

Scheduling: Consistent and timely attendance to your prescribed appointments is crucial in ensuring the best possible outcome from treatment of your condition. We realize that emergencies occur, resulting in the reschedule of appointments. In order to best serve all of our patients, we ask that you notify us 24 hours in advance of a cancellation. Please be aware that failure to attend an appointment without proper notice may result in a \$25 cancel/no show fee charged to you. Repeated disregard for the attendance policy will result in discharge from treatment.

Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the information above or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Patient's Signature

Date

Action Reaction Physical Therapy, Inc.
Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY.

Action Reaction Physical Therapy, Inc. Legal Duty

Action Reaction Physical Therapy, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURE OF HEALTH INFORMATION

Action Reaction Physical Therapy, Inc. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. For example, Action Reaction Physical Therapy, Inc. may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Action Reaction Physical Therapy, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law

In any situation, Action Reaction Physical Therapy, Inc.'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop disclosures at any time.

Action Reaction Physical Therapy, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of you personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Action Reaction Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

Concerns and Complaints

If you are concerned that Action Reaction Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the U.S. Department of Health and Human Services or contact the following office:

Action Reaction Physical Therapy, Inc.
6300 Ninth Avenue N.E.
Suite 360
Seattle, WA 98115
(206) 523-6826

Patient Signature

Date

Patient History



Action Reaction Physical Therapy, Inc.

Name _____ Male Female Date _____
 Age _____ Height _____ Weight _____ Occupation _____

Area of injury/symptoms _____ Date symptoms/injury started: _____
 Diagnosis from your doctor _____ Date of your next doctor recheck: _____

Are you currently off work because of this problem: _____ if yes, last day worked: _____

How did your symptoms start?

How would you describe your problem?

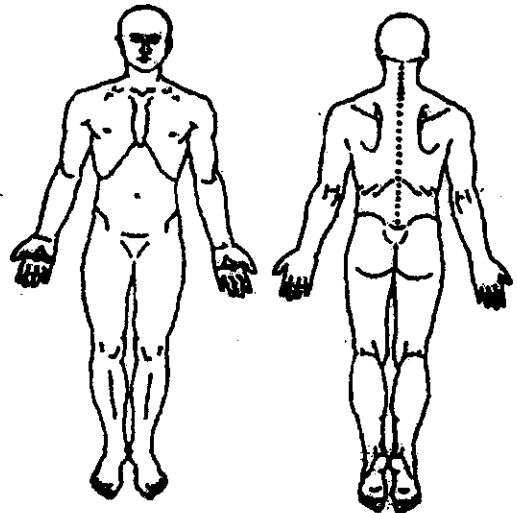
Using the diagram, circle the specific area of pain. If pain travels, draw arrows.

Please **RATE** your pain level:

No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

How would you describe your pain?

- | | | | |
|------------------------------------|------------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Dull ache | <input type="checkbox"/> Burning | <input type="checkbox"/> Heavy | <input type="checkbox"/> Sore |
| <input type="checkbox"/> Deep ache | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Twinge | <input type="checkbox"/> Other |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Cramp | |
| <input type="checkbox"/> Nagging | <input type="checkbox"/> Drawing | <input type="checkbox"/> Sharp | |



What eases the pain?

What aggravates the pain?

Have you had any other treatment for this problem? If yes, what types?

If female, are you pregnant? yes _____ no _____

Have you had x-rays? yes _____ no _____

Please list any other tests you have received.

(Please complete opposite side)

Past Medical History

Have you ever been diagnosed with any of the following conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other arthritic problems | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation/diarrhea |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Chemical Dependency (alcoholism) | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |

Please list any **SURGERIES** or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please describe any **INJURIES** for which you have been treated (including fractures, dislocations, sprains, etc) and the approximate date of injury.

Please describe your normal level of activity:

How often do you take time for exercise?

- Daily
- 3-4 days per week
- 1-2 days per week
- Less than once per week
- Not at all

What exercise do you do?

- walk
- run/jog
- swim
- bike
- other
- gym exercise
- tennis
- golf
- yoga/pilates

Please list all medications that you are currently taking (this includes herbal supplements and over-the-counter drugs)

What are your personal goals for therapy?



Action Reaction Physical Therapy

Cancellation and missed appointments policy

We value your time and hope that you value our time as well. Appointments cancelled less than 24 hours in advance or missed appointments affect our community of patients and physical therapists.

A missed appointment means a physical therapist could not see a patient that might be needing care that day. Therefore, please make note of our cancellation and missed appointment policy below.

- **You (not your insurance company) will be charged \$40.00 for a missed appointment not cancelled at least 24 hours in advance of your scheduled visit.**
- **\$40.00 fee payable upon receipt of invoice.**
- **Exceptions are limited to emergencies.**

We provide reminder calls the day before your appointment as a courtesy. You are responsible for remembering your scheduled appointment at the time you make the appointment. **Stating that you did not receive a reminder call or that the call was made after the 24 hour deadline does not make your missed or cancelled appointment an exception.**

By signing the statement below you are stating that you understand Action Reaction Physical Therapy's cancellation and missed appointment policy.

I the undersigned have been informed about the Action Reaction Physical Therapy 24 hour cancellation and missed appointment policy. I understand that I will be charged, and expected to pay Action Reaction Physical Therapy \$40.00 for appointments not cancelled at least 24 hours in advance, or for any missed appointments.

I have been informed that reminder calls are made the day prior to my appointment as a courtesy but that I am expected to remember my appointment at the time I make that appointment. (Reminder calls are often made less than 24 hours before the scheduled appointment time.)

Signature

Date