Notice to Labor and Industries Patients

To our Labor and Industries patients, we would like to remind you that at time of service we need the following documentation and information from you in order to process your claims with Action Reaction Physical Therapy:

1) Accident Report – readable copy from Attending Physician – please bring to your first appointment or have your attending physician fax to ARPT 206-523-6831.

2) Copy of official "Accepted Claim" letter from Labor and Industries with billable diagnosis codes.

3) Verification of number of allowed physical therapy benefits from Labor and Industries.

4) A signed copy of this letter.

Note: A physical therapy authorization process may be required after 12 visits – this is the responsibility of Action Reaction Physical Therapy to complete the paperwork.

If this information is not received after 1 month of service with Action Reaction PT or your claim cannot be processed for whatever reason, please be advised that you will be treated as a self-pay patient and charged at our self-pay rate of $95 per session for all previous and current physical therapy sessions, payment due upon receipt of statement or at time of service. If in the future your claim is accepted, the $95 out of pocket per session rate will be reimbursed you. We will not bill your medical insurance company until such time Labor and Industries has officially with documentation, denied your claim.

Please note, it is the patient's responsibility to acquire all information that is needed for billing purposes with Labor and Industries. It is also the patient's responsibility to follow up with Labor and Industries to make sure the claim is being processed in a timely manner to avoid the above stated charge per session.

_____

Patient Signature

_____

Date

Welcome to Action Reaction Physical Therapy, Inc.

KNOW YOUR INSURANCE: Your insurance policy is a contract between you and your insurance company. Insurance policies vary, even within the same company. Your insurance company has the final say on what is covered and not covered under your policy. Even though we verify coverage or eligibility for you, ultimately, it is your responsibility to know what your coverage is for services. All questions about your coverage should be directed to your insurance company.

All services you receive here are transactions between you and your health care provider. If the services are not covered by your insurance, you may ultimately be responsible for the cost of these services.

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 company.

THIRD PARTY INSURANCE: In the event your motor vehicle accident involves third party insurance, you may be charged a $50 lien filing fee. This fee will cover the cost of filling 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, debit, cash, Visa, MasterCard and Discover. Insurance co-payments are due at 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 are a non-DME (durable medical equipment) provider and therefore, payment for supplies is due at time of service.

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 office for services are protected against discrimination assured by the 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.

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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**

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.

- **<u>You</u> (not your insurance company) will be charged $50.00 for a missed appointment not cancelled at least 24 hours in advance of your scheduled visit.**
- **$50.00 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. **<u>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.</u>**

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 $50.00 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

Action Reaction Physical Therapy, Inc.
ASSIGNED TO: _____

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 (1st 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

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:

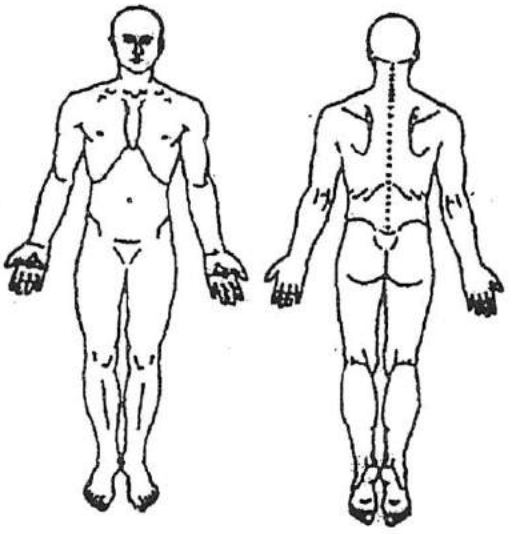
How did your symptoms start?

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?

____Dull ache	____Burning	____Heavy	____Sore
____Deep ache	____Throbbing	____Twinge	____Other
____Stabbing	____Squeezing	____Cramp	
____Nagging	____Drawing	____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?

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

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?