Inglewood Physical Therapy Patient Registration

PATIENT INFORMATION

Patient Last Name	Patient First Name	M.I.	Patient Preferred/Nickname

Mailing Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone
( )	( )	( )

May we send you appointment reminders via text message? ☐ Yes ☐ No, I prefer a phone call reminder.

☐ *I hereby give permission for IPT admin/staff to leave detailed messages on my voicemail/answering machine.*

Email Address

☐ *I hereby give permission for IPT admin/staff to send me emails*

Date of Birth | Sex ☐ M ☐ F | Marital Status ☐ Single ☐ Married ☐ Other | Employer

Referring Physician	Name of Clinic/Hospital	PCP/Family Physician	Name of Clinic/Hospital

Emergency Contact Name	Relationship to Patient

Emergency Home Phone	Emergency Cell Phone	Emergency Work Phone
( )	( )	( )

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company	Policy Holder Name

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent | Policy Holder DOB (if not self)

Member ID	Group Number

SECONDARY INSURANCE

Insurance Company	Policy Holder Name

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent | Policy Holder DOB (if not self)

Member ID	Group Number

If this involves an L&I (work) or car accident claim, please provide the following information:

Claim #	Date of Injury/Accident:	Name of Claims Manager/Adjustor	Phone

Name of worker's compensation office or auto insurance company

ASSIGNMENT/RELEASE:
I authorize my insurance benefits to be paid directly to Inglewood Physical Therapy. I understand that I am financially responsible for any balance due. I authorize Inglewood Physical Therapy or the insurance company to release any information for my medical claims.

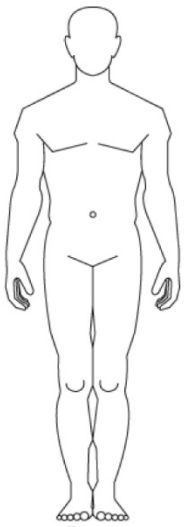
Signature: _____ Date: _____

Inglewood Physical Therapy Subjective History Questionnaire Name: _____ Date: _____

What brings you to physical therapy today and where is the problem area? Please indicate the level of pain you are experiencing in the appropriate area on the drawing below on a scale of 1-10 (0-2 none to mild, 3-4 moderate, 5-6 strong, 7-8 very strong, 9-10 severe/hospital):

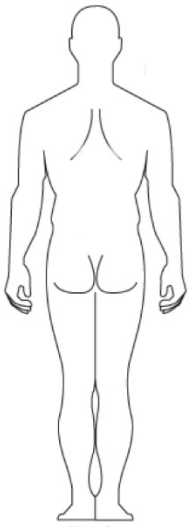
Your Right Side

_____ Neck
_____ Shoulder
_____ Elbow
_____ Forearm
_____ Wrist
_____ Hand
_____ Knee
_____ Foot


Front

Your Left Side

_____ Neck
_____ Shoulder
_____ Elbow
_____ Forearm
_____ Wrist
_____ Hand
_____ Knee
_____ Foot


Back

_____ Upper Back
_____ Lower Back

When and how did it start?

Have you had any X-Ray, MRI or CT scans?

Have you had any previous or ongoing treatment? (e.g. PT, massage, chiropractic, etc)

What activities aggravate your pain? How long into such activity does the pain begin?

What eases it? (e.g. medications, ice, heat, positioning, exercises/stretches, supports, etc.)

Once the pain starts, how long does it take to disappear?

Does the pain wake you up at night?

Subjective History Continued

How do you feel in the morning?

How do you feel at the end of your day?

What is your current occupation?

How often do you exercise?

What are your goals from physical therapy?

Is your condition/injury?

☐ Improving ☐ Not Changing ☐ Worsening

Your Height: _____ Your Weight:_____ Hand Dominance: ☐ Left ☐ Right

Have you had any history of the following? If so, are you taking any medications for these now?

☐	Anxiety/Depression:	
☐	Cancer:	
☐	Diabetes:	
☐	Thyroid:	
☐	Arthritis/Rheumatism:	
☐	Heart (heart attack, pacemaker, stints, etc):	
☐	Lungs/Breathing (COPD, pneumonia, asthma, etc):	
☐	Bowel/Bladder:	
☐	Skin:	
☐	Other:	

INGLEWOOD PHYSICAL THERAPY

NOTICE: PATIENT PRIVACY (HIPAA)

This notice describes the HIPAA Regulations requiring us to protect the privacy of your medical information, how health information about you may be used and disclosed, and how you can get access to your medical records.

We have a detailed "Notice of Privacy Practices" available which fully explains your rights and our obligations under the law. We may revise our notice from time to time. If you wish to receive a detailed copy of the "Notice of Privacy Practices," please let us know.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

As our patient you have rights relating to your medical health information. This includes inspecting and copying your medical information that we maintain, as well as amending or correcting such information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

If you have any questions, concerns or complaints about this notice or your medical information or would like to receive a copy of our detailed Notice of Privacy Practices, please contact Christopher Wong at 425-821-3775.

By signing below, you acknowledge that you have been advised of the Notice of Privacy Practices:

_____ _____

Signature Date

INGLEWOOD PHYSICAL THERAPY

PATIENT/THERAPIST ATTENDANCE AGREEMENT

Thank you for choosing Inglewood Physical Therapy. Our goal is to provide quality patient care in order to assist you in achieving your goals.

We respect that your time is limited and is as important as your therapist's time. If you wait more than 5 minutes past your scheduled time, please notify the Front Desk so they can alert your therapist.

Your time in the clinic will be devoted to manual treatment and/or activities, which require professional guidance. You will also be instructed in those activities which you can perform on your own at home.

To receive the most benefit from your therapy sessions, regular attendance is necessary. We request your assistance with the following guidelines:

Promptness:

Patients are scheduled every 45 minutes and therefore promptness is appreciated. If you arrive 15 minutes later than the scheduled appointment time, your treatment will be shortened or rescheduled.

No Show/Cancellation Policy:

If you are unable to make it to you scheduled appointment, **please notify us within 24 hours to cancel or reschedule** (425-821-3775). If you cancel your appointment without sufficient notice or you are a no show (no call made to our office to notify of cancellation of the agreed upon appointment) **a $35.00 no show fee** will be charged directly to the patient. Two "no-shows" and/or numerous cancellations without notice will result in the loss of your remaining appointments and will be removed from the schedule. If you wish to continue therapy, future visits may be limited to day of scheduling or put on our wait list and we will call you per the availability of the therapist's schedule.

If your therapist if absent, another staff member will see you. If no one is available, your appointment may be rescheduled for another time or canceled. Please inform us if you would prefer to have your appointment canceled rather than be seen by another therapist.

We encourage you to discuss any scheduling concerns with your therapist as we want to make every effort to meet your individual needs.

By signing below, you acknowledge that you understand the above guidelines:

Signature _____ Date _____

INGLEWOOD PHYSICAL THERAPY

INSURANCE BILLING POLICY FOR MEDICARE AND MEDICARE REPLACEMENT PLANS

- Inglewood Physical Therapy will bill medical claims to insurances that we are in-network and credentialed with. We accept original Medicare (red, white, and blue card), Railroad Medicare, and the following Medicare Replacement Plans: AARP Medicare Complete (through United Healthcare), Aetna Medicare, Humana Medicare, Premera Medicare Advantage, and Regence Medicare Advantage.
- As a courtesy, we will check your outpatient physical therapy benefits, but it is also patient responsibility to know what the benefits are as well.
- If you have a deductible that applies to physical therapy benefits, please note that all claims will be subject to that deductible first and will be patient responsibility before your insurance will pay. The original Medicare Part B Deductible is $185.
- If you have a Medicare Replacement plan, most will require a co-payment (typically $20-$45 depending on what plan you have). These are due at the time of service.
- Original Medicare provisions state that you may seek PT treatment without a referral. However, they do require that you be under the care of a physician and they must certify/sign off on our plan of care treatment note. Your physician may or may not require an office visit to them in order for them to sign our note. If you have a Medicare Replacement Plan, they may or may not require a referral to be on file.
- Medicare Replacement Plans may or may not require an authorization for physical therapy treatment. If required, our office will obtain this for you. However, some insurances may require this to be obtained by your referring doctor.
- For original Medicare, they pay 80% of the allowed amount and the remaining 20% is patient responsibility. However, if you have a secondary insurance, the remaining 20% will be billed to them. If you have a deductible to meet or a co-insurance with your secondary insurance, then the balance owing will be patient responsibility. If not, then your secondary insurance should pay for the claims.
- Per original Medicare guidelines, the therapy cap limit is $2,040 combined for physical and speech therapy. If treatment beyond this cap is medically necessary, Medicare will grant a threshold up to $3,000. We may require you to fill out an ABN form if treatment beyond this cap is medically necessary.
- Please let our office know if you've received previous PT or ST for the year whether at our clinic or another. We can help you find out how much money is left on your cap, but it is the patient's responsibility to inform us of this information, otherwise Medicare will not pay if you go over the cap and then payment will be patient responsibility.
- After your insurance(s) processes you claims, we will send you a billing statement with any patient responsibility owing. Statements are mailed out around the 10th of each month and are due the 1st of the following month.
- If needed, we can set-up a payment plan if you cannot afford to pay the balance in full.
- If we do not receive payment in a timely manner and if no payment plan is set-up, your account may be sent to collections.

By signing below, you acknowledge that you have read and understand the above guidelines.

_____ _____

Signature Date