

## EVALUATION INTAKE FORM

Legal First Name \_\_\_\_\_ Last \_\_\_\_\_ M.I. \_\_\_\_\_  
Nick Name \_\_\_\_\_ Maiden Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex: Male/Female Minor: Yes/No  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Can we leave messages?: Yes/No

Referring MD \_\_\_\_\_ Body Area \_\_\_\_\_  
Returning Patient: Yes/No Account# \_\_\_\_\_ Notes \_\_\_\_\_  
Radiology Reports? Yes/No Taken Where? \_\_\_\_\_

Accident Related: Yes/No Type of Accident: WC/MVA/TPL State: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Claim#/I.D. # \_\_\_\_\_ Group# \_\_\_\_\_  
Accident Employer \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Notes \_\_\_\_\_

Mail Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Emergency Contacts:

**Can we release your health/billing info to this person?**

Relationship:	Name:	Phone:	↓↓↓↓↓	
Spouse			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Married Status: Single/Married/Widow/Separated SS# \_\_\_\_\_

Attorney \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Primary Ins. Information: (if other than patient) / Primary Driver (vehicle you were in)

First Name \_\_\_\_\_ Last \_\_\_\_\_ M.I. \_\_\_\_\_  
Sex: Male/Female Date of Birth \_\_\_\_\_ Relationship Spouse/Child/Other

### Secondary Ins. Information / Other Driver

Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_  
ID# \_\_\_\_\_ Group \_\_\_\_\_  
First Name \_\_\_\_\_ Last \_\_\_\_\_ M.I. \_\_\_\_\_  
Sex: Male/Female Date of Birth \_\_\_\_\_ Relationship Spouse/Child/Other

**Tertiary Ins. Information:** \_\_\_\_\_

• I attest that all the information above is correct to the best of my knowledge

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_ Date of Injury \_\_\_\_\_

- How did you hear about us?**
- I was a former patient
  - Doctor
  - Employer
  - Yellow Page
  - Family or Friend Name \_\_\_\_\_
  - Former Patient Name \_\_\_\_\_
  - Case Manager
  - Clinic Sign
  - Insurance Company
  - Web Page
  - Other \_\_\_\_\_

Please list your current problem \_\_\_\_\_  
\_\_\_\_\_

Was this a Work Injury?  Yes  No

Was this related to an Auto Accident?  Yes  No

How were you injured? (If applicable) \_\_\_\_\_  
\_\_\_\_\_

List past injuries, surgeries, accidents, or current medical complications \_\_\_\_\_  
\_\_\_\_\_

Do you have any issues such as heart problems, high blood pressure, diabetes, cancer etc?  
\_\_\_\_\_

What activities increase your pain? \_\_\_\_\_

What activities decrease your pain? \_\_\_\_\_

Surgery for this condition?  Yes  No If Yes, what was your Date of Surgery? \_\_\_\_\_

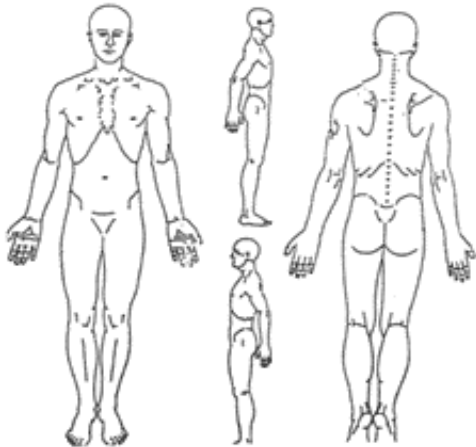
Current Medications \_\_\_\_\_

Please list any other information the therapist needs to be aware of \_\_\_\_\_  
\_\_\_\_\_

Below put and **X** on your pain level while at **REST**: Below put an **X** on your pain level when **Active**:

No pain	_____	Severe Pain	No pain	_____	Severe Pain
	1 2 3 4 5 6 7 8 9 10			1 2 3 4 5 6 7 8 9 10	

Using the picture please mark the location of your complication



**PLEASE CHECK ON BOX ON EACH CATEGORY**

**EXERCISE**

- I have no pain when exercising.
- I have slight pain while exercising but work through it.
- I cannot exercise > 30 minutes.
- I cannot exercise > 15 minutes.
- I cannot exercise without significant pain.
- I cannot exercise at all due to pain.

**SLEEPING**

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of my pain my normal sleep is reduced by %25.
- Because of my pain my normal sleep is reduced by %50.
- Because of my pain my normal sleep is reduced by %75.
- Pain prevents me from sleeping more than one hour at a time.

**SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it almost increases pain immediately.

**STANDING**

- I can stand as long as I want without pain.
- I have some pain while standing but can stand as long as I have to.
- I cannot stand longer than one hour without increasing pain.
- I cannot stand longer than ½ hour without increasing pain.
- I cannot stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases pain almost immediately.

**PERSONAL CARE**

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of dressing or washing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing or dressing without help.
- Because of the pain I am unable to do any washing or dressing without help.

**WALKING**

- I have no pain while walking.
- I have some pain while walking but I work through it.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 3-4 blocks without increasing pain.
- I cannot walk more than 1-2 blocks without increasing pain.
- I cannot walk more than 10 feet without increased pain.

**LIFTING**

- I can lift heavy weights without pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor > 30#
- Pain prevents me from lifting heavy weights off the floor > 20#
- Pain prevents me from lifting heavy weights off the floor > 10#
- I can only lift very light weights less than 5#

**SOCIAL LIFE**

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests. (e.g. dancing)
- Pain has restricted my social life and I do not go out much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

**CHANGING DEGREE OF PAIN**

- Pain is rapidly getting better.
- Pain fluctuates but overall is definitely getting better.
- Pain seems to be getting better but improvement is slow.
- Pain is neither getting better nor worse.
- Pain is gradually worsening.
- Pain is rapidly worsening.

**TRAVELING**

- I get no pain while traveling.
- I get some pain with traveling which can be relieved with changes of position.
- I get extra pain with while traveling that I cannot relieve with changes of position.
- I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel that done while lying down.
- Pain restricts all forms of travel.

## ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

**P. T. Northwest of Longview, 1560 3<sup>rd</sup> Avenue, Longview, WA 98632**

For the professional expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original.

By executing this agreement, I am agreeing to pay for all services that are received.

Patient's Name (Please print) \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## P.T. NORTHWEST PRACTICE AND FINANCIAL POLICIES

I have been given a copy of PT Northwest policies and procedures.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## P. T. NORTHWEST AUTHORIZATION TO TREAT (MINOR/GUARDIANSHIP)

PATIENT INFORMATION:

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

PARENT OR GUARDIAN INFORMATION:

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

I certify that I am the parent or legal guardian of the above named patient. I hereby authorize the physical therapy, occupational therapy, or massage therapy staff at **P.T. Northwest** to treat the above named patient without my being present in their facility.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- **Contact your insurance company to verify your physical therapy benefits.**
- **Information provided by the insurance company is not a guarantee of payment.**
- **Co-payments are due at the time of service.**
- **Cancels and no-shows are not covered by insurance.**

## **P.T. NORTHWEST PRACTICE AND FINANCIAL POLICIES**

We strive to provide you with the best-personalized care available. To make this possible we adhere to a set of very important policies.

### **INSURANCE CLASSIFICATION**

**PRIVATE**-Private medical insurance carriers have their own specific rules and regulations. Most have a yearly maximum allowance for physical therapy. If you are on a network or PPO plan, you must comply with your carrier regarding all precertifications, authorizations, benefits, and co-payments required. Your insurance is a contract between you and the insurance company. We are not a party to this contract. Please remember that payment of all charges is your responsibility. We will bill both your primary and secondary insurance if we are provided with the required information in a timely manner. Patient co-payments are due at the time of each visit, and patient responsibility portions are due within 30 days of receipt of your monthly statement.

**WORK INJURY**-We will directly bill the worker's compensation department for on-the-job injuries. We keep in close contact with your claims manager, and are required to provide information such as progress and attendance compliance. We will contact your worker's compensation carrier to verify eligibility and claim status. If you have attorney representation, we request their name and telephone number. If your worker's compensation claim is denied, you will be financially responsible for all outstanding charges. If you receive denial notification on your worker's compensation claim, you need to notify our billing department. If you have personal health insurance, we will then process your claim through that insurance carrier.

**MOTOR VEHICLE/THIRD PARTY LIABILITY**-Washington motor vehicle code requires that we bill the insurance carrier of the vehicle you were riding in first, even though the accident may have not been your fault. Please provide us with the claim number for that auto insurance carrier, as well as the information from the other party involved in your accident. If you have attorney representation, we request their name and telephone number. Please be advised that we cannot allow your account to become financially unmanageable and we may need to arrange a financial plan of payment with you and, if requested, your attorney.

### **CANCELLATION / NO-SHOW POLICY**

**Cancellations:** If you wish to change or cancel an appointment, we require a minimum 24-hour advance notice. Anything less than that will result in a \$10 fee that is your responsibility to pay as insurance does not cover cancellation charges. We do not make money by charging this fee. We would rather be helping patients during the appointment time slot, however on short notice it is hard to place another patient in your time slot. This fee is established to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve in place of you. Please be courteous and responsible. Thank you.

**No-Shows:** Failing to show for an appointment will result in a \$25 fee that is your responsibility to pay, as insurance does not cover no-show charges.

### **MONTHLY STATEMENTS**

If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account in the last billing period.

### **PAYMENTS**

The balance on your statement is due 30 days after the receipt of your statement and to be paid in full unless other arrangements have been made that is acceptable to both parties. If you have financial questions or concerns at any time, please do not hesitate to speak with our billing department.

### **RETURNED CHECKS**

There is a fee (currently \$25) for any checks returned by the bank.

### **PAST DUE ACCOUNTS**

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer you account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. If we have to litigate in court, the fact that you received treatment at our office may become a matter of public record. In case of suit, you agree the venue shall be in Cowlitz County, Washington.

### **FINANCE CHARGE**

A finance charge will be imposed on each item of your account, which has not been paid within ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits to the account during that time

### **MEDICAL CONSENT**

You authorize P.T. Northwest to perform an evaluation and any resulting treatments for your current condition and other conditions at your request. You understand that this may include manual testing, measurement of joint and muscle function, manual therapy techniques, therapeutic exercises, palpation, and modalities such as electrical stimulation or ultrasound. You understand that you will be asked to fill out a medical questionnaire and various evaluations will be performed to assure your safety and well being during the evaluation and treatment process. You understand that you are being seen under Direct Access in accordance with all appropriate regulatory agencies. You understand that no P.T. Northwest representative will ask you to do anything that intentionally hurts or injures you. You understand that you have the right to revoke consent at any time in writing.

### **RESPONSIBILITY FOR PERSONAL PROPERTY**

P.T. Northwest is not responsible for any items that you, the patient, bring into the facility.

### **TRANSFERRING OF RECORDS**

You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

### **DIVORCE**

In case of divorce or separation, the party responsible for accruing the account prior to the divorce or separation remains responsible for the account.

### **MINOR CHILDREN**

The parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If a divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

# **PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

Our commitment at P.T. Northwest is to serve our customers with care and professionalism, being sure at all times to protect the privacy and security of all Protected Health Information (PHI).

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire x-rays and other diagnostic reports.
- For payment collection purposes, we may need to obtain updated billing information from your referring physician, attorney, or use the services of a collection agency
- During health care operations, we may need to obtain updated information from your referring physician, attorney, case manager, and/or claims manager.

The staff at P.T. Northwest is committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at (360) 423-9535.

**I have read and understand the above Notice of Privacy Practices. I further understand that I have the right to receive a detailed copy of the Compliance Plan and Notice of Privacy Practices for P.T. Northwest, Inc. if I so desire one.**

Name of Patient (please print) \_\_\_\_\_

Signed \_\_\_\_\_  
(Patient or Legal Guardian)

Date \_\_\_\_\_