

**PATIENT INFORMATION** – Please Print Clearly

**Today's Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Patient Social Security Number (Adults only): \_\_\_\_\_  Male  Female Age\_\_

**IF child please complete** -Legal guardian Name \_\_\_\_\_ SSN# \_\_\_\_\_  
2<sup>nd</sup> Legal guardian's Name \_\_\_\_\_ SSN# \_\_\_\_\_

Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Billing address if different than above: \_\_\_\_\_  
\_\_\_\_\_

Physician authorizing Therapy: \_\_\_\_\_

Patient Marital Status:  Single  Married  Other  **Child**

Is the Patient Employed:  Yes  No  Full-time  Part-time

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

1. May we leave messages regarding appointments on primary phone#? YES NO If not what #  
\_\_\_\_\_
2. Are there any members of your family or household with whom we should NOT discuss health care issues and why? \_\_\_\_\_

**School name** \_\_\_\_\_ **Child attends - full time** \_\_\_\_\_ **Part time** \_\_\_\_\_

**INSURANCE INFORMATION** – In order to bill your insurance(s), we must have a copy of your card(s)

Primary Ins Co: _____	Secondary Ins Co: _____
Verification Ph #: _____	Verification Ph #: _____
Policy ID #: _____	Policy ID #: _____
Group #: _____	Group #: _____
<b>Subscriber's Name:</b> _____	<b>Subscriber's Name:</b> _____
<b>Subscriber's Employer:</b> _____	<b>Subscriber's Employer:</b> _____
<b>Relationship to Patient:</b> _____	<b>Relationship to Patient:</b> _____
<b>Subscriber's DOB:</b> _____	<b>Subscriber's DOB:</b> _____

**EMERGENCY CONTACT**

Name of person not living with you: \_\_\_\_\_ Phone:( \_\_\_\_\_ ) \_\_\_\_\_

**Dietary restrictions and allergies:** \_\_\_\_\_  
\_\_\_\_\_

In the event of an emergency I give permission to Bothell Pediatric and Hand Therapy consent to treat my child if necessary. I understand the staff is trained in CPR and First aid. I understand by not signing this I will be here at all times to give treatment.

Parent or Legal Guardian Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_

I authorize the following adults to accompany child for therapy \_\_\_\_\_ ; \_\_\_\_\_



# Patient Health Information Policy

## **Patient Privacy & HIPAA (Health Insurance Portability and Accountability Act) Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to evoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

\_\_\_\_\_  
**Patient, Parent or Guardian's Signature**

\_\_\_\_\_  
**Date**

**Printed Name of Patient:** \_\_\_\_\_

**Relationship** \_\_\_\_\_

If signed on behalf of patient

**I understand and agree that therapeutic activities and performance may be discussed in the waiting room. Initial here** \_\_\_\_\_



## **PHOTO / VIDEO AUTHORIZATION**

I hereby authorize Bothell Pediatric and Hand Therapy to photograph and/or videotape for the purpose of documentation which will be kept as part of the patient's permanent file. Photo's may be taken and used for website or promotional material. You will be notified first.

## **Electronic Media Authorization**

Email communication provides a fast and easy way of communication within the healthcare field for non-urgent issues. General considerations: Email communication will be treated with the same confidentiality as written medical records and kept as a permanent record. Standard email communication services such as AOL, Yahoo and hotmail are not secure. This means that email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.

Your email address will not be given out for external marketing. You may receive emails from us such as promotional material and newsletters. Recipients' email addresses will be hidden.

Every attempt will be made to respond to emails within 2 business days. *If you have not received a response please contact the office by phone.*

Email messages should not be used for emergencies, or sensitive material. For time sensitive or material sensitive items please contact the office by phone.

Email messages should be concise and please include full names for identification.

I understand I may revoke my consent to communicate via email by notifying the practice in writing. I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network.

I would like to receive BPHT's monthly newsletter "*Hands on Health*"

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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**Patient/Guardian's Signature**

**Date**

Verified by \_\_\_\_\_ (if appropriate).

Opt out option: I opt out of all above authorizations

Opt out of Video/photo authorization only

Opt out of Electronic media authorization only

**AUTHORIZATION FOR EXCHANGE OF INFORMATION**

PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

Legal Guardians' Names \_\_\_\_\_

**Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the exchange of medical records, school records, clinic notes and pertinent information regarding the treatment/program development of this patient between:



18504 Bothell Way NE  
Bothell, WA 98011

Phone 425-481-1933 / Fax 425-481-9371

I have a **nanny** or **caregiver** who may bring them to their visit YES / NO and authorize you to discuss information regarding my child's visit with (please print name) \_\_\_\_\_ at their visit YES/NO

I authorize you to release evaluations, progress reports and exchange information to: primary care physician, referring physician, schools, other therapists, hospitals or family members:

Facility Name \_\_\_\_\_

Person/Professional: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ / \_\_\_\_\_

Facility Name \_\_\_\_\_

Person/Professional: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ / \_\_\_\_\_

Facility Name \_\_\_\_\_

Person/Professional: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ / \_\_\_\_\_

Facility Name \_\_\_\_\_

Person/Professional: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ / \_\_\_\_\_

Facility Name \_\_\_\_\_

Person/Professional: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ / \_\_\_\_\_



# Insurance Waiver & Cancellation Policy

## Insurance Waiver

**(Signature required by all clients – regardless if claims are or are not submitted)**

I understand that my insurance company may or may not consider the Occupational, Speech Language Pathology, Physical Therapy, Massage or Durable Medical Equipment services provided by *Bothell Pediatric & Hand Therapy* to be a covered medical expense.

I understand that even when Occupational, Speech Language Pathology, Physical Therapy, Massage or Durable Medical Equipment services are prescribed by my physician and listed as being a covered medical expense on my insurance plan, payment is not guaranteed. Upon receipt of claims for services rendered, my insurance company will review for medical necessity and based on that review, the services *may not be considered to be medically necessary or may be considered as non-covered expenses* and may not be paid by my insurance company.

I elect to have *Bothell Pediatric & Hand Therapy* provide Occupational, Speech Language Pathology, Physical Therapy, Massage or Durable Medical Equipment services for myself or my child. I understand that if my insurance company does not allow benefits or approve payment of claims for services I/my child have/has received, *I am responsible for all incurred charges and I agree to pay the balance in full*. I hereby authorize payment from my insurance company directly to *Bothell Pediatric & Hand Therapy* for services provided.

## No Show/ Late Arrival/Cancellation Policy

**Please notify our office 24 hours in advance or more if you must reschedule your appointment.** Patients on our waiting list can be seen when we have these openings.

- “Late cancellations” (cancellations LESS than 24 hours prior to the scheduled therapy visit) are costly to our office and will be assessed a \$50.00 fee, charged directly to the patient.
- “No-Shows” (appointments not held by the patient, with no call made to our office to notify of cancellation of the agreed upon appointment) will be charged at the cash pay rate of \$120.00 directly to the patient.
- Two “No-shows,” and/or numerous cancellations will result in loss of your therapy time slot.
- Appointments missed more than 2 weeks in a row within a 6-month period (i.e. for vacations or other reasons) will result in loss of your therapy time slot. If a patient will be gone more than 2 weeks in a row and you want to keep the spot/s, you can choose to cash pay for those visits you will miss in order to reserve your spot.
- Patients arriving for their appointment more than 15 minutes late will have a \$30.00 fee charged directly to the patient; 20 minutes late will be assessed at \$60.00. More than 30 minutes late (or half of session) will be charged a \$120.00 no show fee.

It is not our intention to cause undue hardship; however we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read and understand the *Cancellation Policy for Bothell Pediatric & Hand Therapy*.

**Patient, Parent or Guardian's Signature** \_\_\_\_\_

**Date**

**Printed Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**FOR USE BY OFFICE: Witnessed by** \_\_\_\_\_





# Contract for Services

RE: (Patient's Name) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that as a courtesy, *Bothell Pediatric & Hand Therapy (BPHT)* has contacted my insurance company to see what therapy benefits apply to my plan. As benefits are often misquoted over the phone, I do not hold *Bothell Pediatric & Hand Therapy* responsible for the information received. Final decision on benefits is determined when a claim is submitted and either paid or denied based on determination from my insurance company. I understand that I am responsible to confirm that *Bothell Pediatric & Hand Therapy* is a contracted provider with my specific insurance plan and to verify the benefits allowed for Occupational, Speech Language Pathology, Physical Therapy, or Massage services. The contract with the insurance company is between the company and me; *Bothell Pediatric & Hand Therapy* is not involved and does not accept responsibility for negotiating settlement of a disputed claim. In addition, we will not await payment/resolution from third party liability carriers or from a carrier with whom *Bothell Pediatric & Hand Therapy* does not hold a contract for the date of service.

I understand that I am responsible to obtain a physician prescription for all services and my insurance company may also require a referral and/or insurance authorization. I understand that it is my responsibility to keep track of the number of visits used relative to those authorized, the expiration date of any authorization and/or the contract limitations of my insurance plan. If progress reports and/or treatment plans are required by my physician or insurance company, I will notify my therapist at least one month before they are due, to allow time for completion of the paperwork. If insurance is billed by *Bothell Pediatric & Hand Therapy*, my insurance company may request information regarding my child's treatment and I give my consent for the release of this information.

- Insurance co-pays are due at the time of service.
- I understand that I am responsible for payment of my account on a timely basis, whether payments are made by me or by my insurance company.
- If claims are submitted to insurance and payment is not received within 45 days, I agree to follow up with the insurance company regarding payment and personally make regular payments to *Bothell Pediatric & Hand Therapy* on my account.
- All charges are due in full within 60 days from date of service unless a separate payment arrangement has been approved and signed by both *Bothell Pediatric & Hand Therapy* and myself.
- In the event that my insurance company denies payment, I am fully and directly responsible for the payment of all charges. My portion of the bill is due upon receipt of the statement.
- Any unpaid patient balances over 60 days will be charged 1½% interest (18% annually).
- Patient balances unpaid over 90 days will be sent to collections.

As part of ongoing therapy services, the treatment sessions are billed to insurance at \$160 per hour for Occupational and Physical Therapy sessions and \$130 for Speech Language Therapy sessions. A cash discounted rate is available at \$120.00 per hour for Occupational and Physical Therapy and \$110 for Speech Therapy, if paid at the time of service. Evaluations are billed at \$290 to insurance for Occupational and Physical Therapy and discounted to \$240 for patients' cash pay price, if paid at the time of service. Evaluations are billed at \$220 to insurance for Speech Language Pathology and discounted to \$180 for patients' cash pay price, if paid at the time of service. Evaluations for Hand Occupational Therapy are billed at \$170 to insurance plus procedures and splinting done by the therapist, and are discounted 15% for patients' cash pay price, if paid at the time of service.

**Patient, Parent or Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship \_\_\_\_\_



### Medical Profile Questionnaire

Please fill out the following questionnaire as completely as possible. This enables your Physical Therapist to establish a clinical profile upon which a safe and appropriate therapy program is planned. Your input is very important

Where is your pain? Using the following symbols, please mark on the drawing the areas where you feel pain:

**Symbols:**

- Pain (circle area)
- Numbness // // // // //
- Pins/Needles : : : : : :
- Shooting pain ↓

What does the pain feel like? (sharp, aching, burning, etc.)

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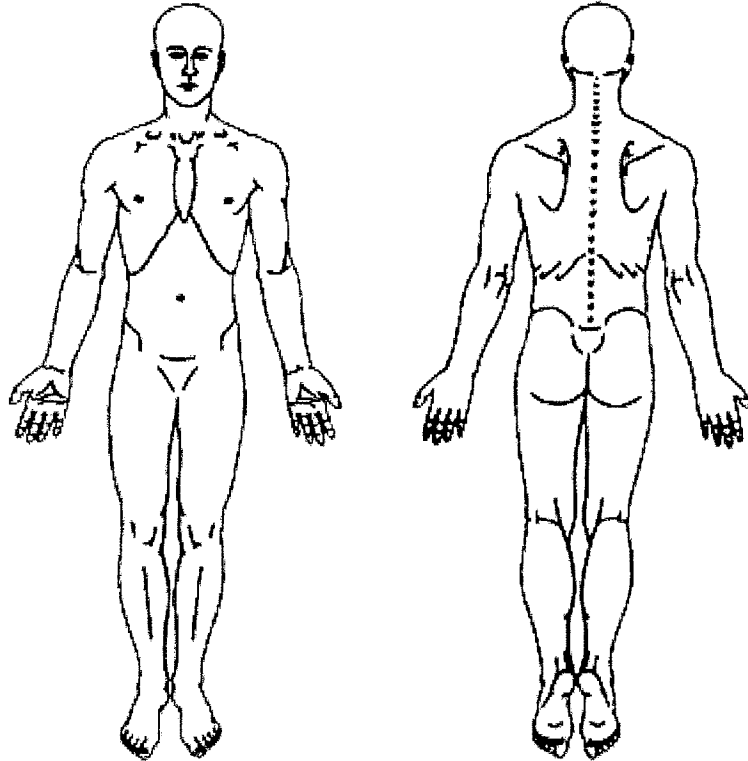
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Date of onset:

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If this was an injury, check the appropriate boxes. Briefly describe how it happened.

- Motor vehicle     Work injury     Sports     Other

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On a scale of zero to ten, with zero (0) being "NO PAIN: or "PAIN FREE" and ten (10) as the "WORST PAIN" you can imagine, rate:

The best it has been \_\_\_\_    The worst it has been \_\_\_\_    Your pain today \_\_\_\_

What makes your pain symptoms BETTER?

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Have you had this problem before?    \_\_ YES    \_\_ NO

**IMPORTANT: PLEASE COMPLETE OTHER SIDE →**

**Referring Physician:**

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**Date of last doctor's visit/exam:**

**Date of next visit/exam:**

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**Family Physician/Internist:**

**Month/year last visit:**

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**Check if you take any of the following MEDICATIONS:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Steroids (cortisone)       | <input type="checkbox"/> Anti-inflammatory                   | <input type="checkbox"/> Pain killers       |
| <input type="checkbox"/> Muscle relaxants           | <input type="checkbox"/> Anti-coagulants<br>(blood thinners) | <input type="checkbox"/> Insulin (diabetes) |
| <input type="checkbox"/> Blood pressure medications | <input type="checkbox"/> Heart medication                    | <input type="checkbox"/> Other _____        |

**I have a history of (check any that apply):**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer/tumors                 | <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Poor Circulation                     |
| <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Epilepsy/seizures                 | <input type="checkbox"/> Bruising easily                      |
| <input type="checkbox"/> Shortness of breath           | <input type="checkbox"/> Blackouts                         | <input type="checkbox"/> Asthma                               |
| <input type="checkbox"/> Heart trouble/angina          | <input type="checkbox"/> Frequent falls                    | <input type="checkbox"/> Hearing problems                     |
| <input type="checkbox"/> Coronary artery disease       | <input type="checkbox"/> Severe pain at night              | <input type="checkbox"/> Thyroid problems                     |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Night sweats                      | <input type="checkbox"/> Bladder problems                     |
| <input type="checkbox"/> Pacemaker/Nitroglycerin patch | <input type="checkbox"/> Smoking                           | <input type="checkbox"/> Chest/abdominal or<br>pelvic surgery |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Recent & sudden weight<br>changes | <input type="checkbox"/> Headaches                            |

For WOMEN (check if yes):

- I have had a recent pelvic exam (PAP)
- I am or may be PREGNANT
- I have had a recent mammogram or breast exam

For MEN (check if yes):

- I have had a recent prostate exam

**Allergies:** Medications, food other (i.e. tape, beeswax, etc). List reactions (such as hives, rash, shock, tongue swelling, breathing difficulty, etc.)

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**Surgery:**

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**Imaging:** X-Rays, MRI, CT (specify by name and dates of studies & results if known):

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Patient signature:

Date:

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