# Life in Balance Physical Therapy & Pilates

**5410 California Ave SW, #101**
**Seattle, WA 98136**
**P (206) 913-8082, press 1**
**F 1-206-935-0357**

**19711 1st Ave S**
**Normandy Park, WA 98148**
**P (206) 913-8082, press 2**
**F 1-206-316-8373**

## PATIENT INFORMATION

First Name: _____ MI: ___
Last Name: _____
Preferred Name: _____
Home Address: _____
City: _____
State: _____
Zip Code: _____

Date: _____
Date of Birth: ____/____/_____
Social Security Number: ___/___/____
Biological Sex: _____
Marital Status: Single Married Other
Home Phone: _____
Cell Phone: _____
E-mail address: _____

Employment Status: Employed Full-time Student Part-time Student N/A

Is it okay for the therapist / receptionist to leave a message on your **cell / home** phone regarding future appointments?
Please circle one or more.

Is it okay for the therapist / receptionist to leave a message on your **cell / home** phone containing medical information?
Please circle one or indicate NO.

## EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

Name: _____ Phone Number(s): _____
Relationship: Spouse Parent Other _____

## REFERRING PHYSICIAN INFORMATION

Name: _____ Phone Number: _____

## REASON FOR TODAY'S VISIT

In which area of the body is your chief complaint?

Head Neck Shoulder Elbow/Wrist/Hand Back Pelvis Tailbone Hip Knee Ankle/Foot

Pelvic Floor: Pain Incontinence Post-Surgery Sexual Dysfunction Pre-Post-Partum

Other _____

## PLEASE TELL US HOW YOU HEARD ABOUT LIFE IN BALANCE PT & PILATES

☐ My Doctor _____
☐ Family/Friend _____
☐ Insurance Website _____
☐ Another Healthcare Practitioner _____
☐ Internet Search: Google Yelp Facebook Other _____
☐ Other _____

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## INSURANCE COMPANY INFORMATION AND/OR CLAIM INFORMATION

**Personal Insurance Company**:_____

Identification Number: _____ Group Number: _____

Policyholder *(if other than patient)*: _____

Relationship to Patient: _____ Date of Birth *(of policyholder)*: ____/____/____

Phone *(of policyholder)*: _____ SSN: _____

**Motor Vehicle Accident Insurance Company**: _____

Date of Accident: _____ Claim Number: _____

Adjuster Name: _____ Adjuster Phone Number: _____

**Worker's Compensation Insurance Company**:_____

Date of Injury: _____ Claim Number:_____

Claim Manager Name: _____ Phone Number: _____

Please note: if you are an L&I patient, your visit may only be 40 minutes as this is the maximum time for which L&I will reimburse.

## 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: _____**

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

I hereby assign all medical benefits to which I am entitled to Life in Balance Physical Therapy and Pilates, LLC in the event they file insurance on my behalf**. I understand that I am financially responsible for all charges whether or not paid by insurance**. In the event my account becomes delinquent and is therefore 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 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 Life in Balance Physical Therapy and Pilates, LLC 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.

**Signature**:_____**Date**:_____

## RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

I acknowledge that I have received a copy of the notice of patient privacy practices (page 7), as outlined by the Health Insurance Portability and Accountability Act of 1996.

**Signature**:_____**Date**:_____

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## AUTHORIZATION FOR TREATMENT

The undersigned hereby authorizes the physical therapists at Life in Balance Physical Therapy and Pilates, LLC to provide physical therapy treatments deemed necessary for my care. I understand that this type of treatment involves the use of touch for diagnosis and treatment and that my therapist will explain this approach to me.

## AUTHORIZATION FOR CHARGES

The undersigned hereby authorizes my insurance benefits to be paid directly to Life in Balance Physical Therapy and Pilates, LLC including health insurance, Personal Injury Protection, Labor and Industries, or other applicable coverage. **I fully understand and agree that I am financially responsible for any and all balances due**. **I also understand that it is my responsibility to determine the physical therapy benefits that apply to my specific insurance plan. This includes, but is not limited to, necessary doctor referrals or prescriptions, deductibles, co-pays, percentage pay out, provider discounts, and yearly coverage.**

Balances held over 90 days are subject to an interest and records-keeping fee of $5 per month and may be sent to a collection agency. **Patients must keep their account balances under $300 to continue treatment.**

## CANCELLATION AND LATE POLICY

While you are under the care of a Life in Balance Physical Therapist we will take special care to respect your one-to-one time with the therapist. Each visit, whether for physical therapy or for a Private Pilates session, is **55-minutes** in length and you will be treated solely by a licensed physical therapist. In order to continue to offer such a high quality of care, we ask that you **arrive on time for your appointments and give 1 full business day of 24 hours notice in the event that you need to cancel a scheduled appointment. If 24 hours' notice is not given, you will be charged a $75 fee. This amount is <u>not</u> covered by insurance.**

_____**Please initial your understanding that if you need to cancel a Monday appointment, you must do so on Thursday to avoid the $75 cancellation fee.**

1st cancellation/no show without 24-hr notice—no fee, forgiven.
2nd cancellation/no show without 24-hr notice—**$75 fee**.
3rd cancellation/no show without 24-hr notice—**$75 fee**.

After the 3rd incident, if you have not been in contact with us, we will automatically cancel all future appointments. If you would like back on the schedule, your account must have a zero balance and you agree to pay **$125** for any additional late cancellation/no show.

**I understand that if I am late and/or am not able to give 24 business hours' notice cancellation for my appointments that the above cancellation policy applies and is not a fee that is covered by insurance.**

_____ _____
**Signature of Patient or Party Responsible for Bill** **Date**

_____
**Printed Name**

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## BILLING INFORMATION

Welcome to Life in Balance. We are excited to work with you and be a part of your healthcare team. Here is some information we would like you to review to improve the understanding of the billing process. Please know we do our best to assist you in understanding your insurance benefits. **However, it is <u>your</u> responsibility to know your insurance coverage and benefits.**

### INSURANCE COVERAGE

At any given time, Life in Balance Physical Therapy and Pilates, LLC is contracted with specific insurance companies. We do our best to verify your insurance benefits; however, **quoted benefits are not a guarantee of payment and it is your responsibility to know your insurance coverage.**

_____ **Please initial your understanding that it is your responsibility to know your insurance coverage**.

### PATIENT PAYMENTS

**Co-pays are due at the time of service. Patients with a deductible will pay $100.00 toward their deductible each visit and will be billed for any remaining amount until the deductible is met.** Prepaid co-insurance payments are highly recommended. Please note that the amount collected is an estimated amount. Co-insurance amounts are fully calculated after your insurance has processed the claim. For information regarding this percentage, contact your insurance company.

Once an insurance claim is processed, you will receive an EOB (Explanation of Benefits) from your insurance company, detailing the “amount paid by insurance” and the “patient responsibility.”

Please be aware, we send bills to patients the first week of each month. If your claims have not yet processed through insurance, you will not receive a bill for your portion immediately. The claims process generally takes anywhere from 15 to 90 days. Bills will reflect only the amount currently owed. Your payment is due upon receipt of the bill. Please be advised that unpaid bills, and accounts with balances over $300, may result in Life in Balance discontinuing treatment.

### CASH PAY

Payment is expected at time of service. The rate quoted to you is a discounted rate.

### PERSONSAL INJURY PROTECTION (PIP) CLAIMS

Please be aware of the monetary limit of your PIP coverage. If it appears you have or will exhaust your PIP, be prepared to provide personal health insurance to cover your visits. If you do not have personal health insurance, please read the 3rd PARTY section below.

### THIRD PARTY PIP

At this time, we accept 3rd party PIP on a limited basis—only after you have exhausted your PIP funds and are working with an attorney. At that time, we will need you to acquire a “letter of guarantee” from your attorney. Given that we will be continuing care without payment at time of service, we will be not discount or negotiate our fees at the time of the settlement. All outstanding balances will be due in full to Life in Balance Physical Therapy and Pilates, LLC. You always have the option of paying as a “cash pay” patient for each visit if you would like to reduce the cost of each visit.

I have read and understand the billing information listed above.

**Signature: _____ Date: _____**

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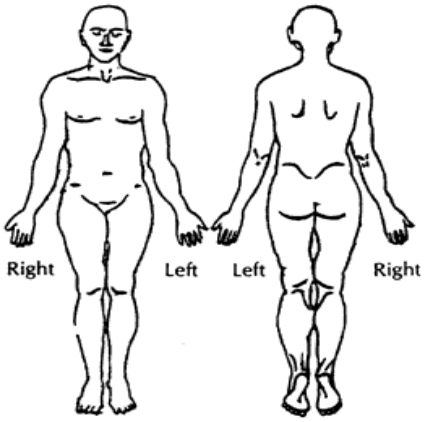
## MEDICAL HISTORY AND SYMPTOM DESCRIPTION

Name: _____ Age: _____ Date of Injury/Surgery: _____

Occupation: _____ Please circle: Full / Part Time Currently Working Y / N

How do you identify? _____ Circle today's pain level: 0 1 2 3 4 5 6 7 8 9 10

Mark areas of symptoms you may experience.




Describe your injury or symptoms:

_____

_____

_____

I feel **BETTER** with_____

**WORSE** with _____

Circle today's pain level: 0 1 2 3 4 5 6 7 8 9 10

Please circle the activities you are having **DIFFICULTY** or discomfort performing as a result of your injury:

| | | | |
|---|---|---|---|
| Sleeping | Looking over shoulder | Reaching overhead/ behind back/across body | Lifting/carrying |
| Grooming | Looking up or overhead | Stairs: Up/Down | Pushing |
| Dressing | Sitting | Walking | Pulling |
| Household Chores | Standing | Squatting | Kneeling |

**Diagnostic Testing**: X-Ray MRI CT Scan Other: _____
**Prior treatments and results**:_____

**Have you EVER been diagnosed as having any of the following conditions?**

YES NO Cancer, type _____
YES NO Heart Problems_____
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Diabetes
YES NO Thyroid Problems
YES NO Kidney Disease_____
YES NO Liver Disease_____
YES NO Stroke/Brain Injury
YES NO Seizures_____
YES NO Multiple Sclerosis
YES NO Chemical Dependency (i.e., alcoholism)
YES NO Arthritis/DDD
YES NO Asthma
YES NO Stomach Ulcers
YES NO Incontinence
YES NO Osteoporosis
YES NO Rheumatoid Arthritis
YES NO Blood Clots
YES NO Depression
YES NO Other

**In the last 6 months have you experienced?**

YES NO Dizziness
YES NO Double Vision
YES NO Fainting
YES NO Falls/Balance Problems
YES NO Headaches
YES NO Numbness/Tingling
YES NO Nausea/Vomiting
YES NO Weight Change
YES NO Incontinence
YES NO Night Time Pain
YES NO Pregnancy
YES NO Illness/Fever/Infection

**Pertinent surgeries and/or medical procedures**: _____

**MEDICATIONS**: _____

**GOALS:** _____

*I understand the above information represents my health and symptoms. It is accurate to the best of my knowledge. I understand that this information will be used to provide a personalized treatment plan for me.*

**Patient / Guardian Signature: _____ Therapist:_____**

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**NAME** _____ **DATE** _____

**PATIENT-SPECIFIC FUNCTIONAL SCALE (PSFS)**

**Please list 3 activities that you are unable to do or have moderate to extreme difficulty performing as a result of your injury or pain level. Please circle the corresponding level of difficulty.**

**0 = UNABLE TO PERFORM** **10 = ABLE TO PERFORM ACTIVITY AT SAME LEVEL AS BEFORE THE PROBLEM OR INJURY**

**1.** _____ **0 1 2 3 4 5 6 7 8 9 10**

**2.** _____ **0 1 2 3 4 5 6 7 8 9 10**

**3.** _____ **0 1 2 3 4 5 6 7 8 9 10**

**PAIN LEVEL:** **0 1 2 3 4 5 6 7 8 9 10**

**0=NO PAIN**

**10=MOST INTENSE PAIN IMAGINABLE**

**Your percentage of time at this level:** **0-25%** **26-50%** **51-75%** **76-100%**

**Office use only:**
**sum of scores/number of activities**
**detectable change for average score = 2 points minimum**
**detectable change for single activity = 3 points minimum**

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## HIPAA FORM -- NOTICE OF PATIENT PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirmation coverage, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits or services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the office director (privacy officer).

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a required restriction. If we do agree to a restriction we must abide by it unless you agree to it in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect or copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. The notice is effective as of June 10, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all health information that we maintain. We will post and your may request a written copy of a revised Notice of Privacy practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written notice, with our office or the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you in any way for filing any such complaint. Please contact us for more information, by asking to speak to our Privacy Officer or for written inquires note “Attention Privacy Officer.” For more information about HIPAA or to file a complaint you may contact the U. S. Dept of Health and Human Services at the address below:

*The U.S. Department of Health and Human Services*
*Office of Civil Rights*
*200 Independence Avenue S.W.*
*Washington, DC 20201*
*Toll Free: 1 (877) 696-6775*