Life in Balance Physical Therapy & Pilates
5410 California Ave SW #101
Seattle, WA 98136
LifeinBalancePhysicalTherapy.com

P (206) 913-8082
F (206) 935-0357

PATIENT INFORMATION

Date: _____

First Name: _____ MI: ____ Date of Birth: ___/___/_____

Last Name: _____ Social Security Number: ____/___/____

Preferred Name: _____ Female / Male

Home Address: _____ Marital Status: Single Married Other

City: _____ Home Phone: _____

State: _____ Cell Phone: _____

Zip Code:_____ E-mail address: _____

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

Employer Name/School Name: _____

Work Phone: _____ Title/Position: _____

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

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

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

First Name: _____ MI: ___ Home Phone: _____

Last Name: _____ Cell Phone: _____

Relationship: Spouse Parent Other _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Phone Number: _____

Address: _____

REASON FOR TODAY'S VISIT

In which area of the body is your chief complaint? Neck Shoulder Elbow/Wrist/Hand Back Pelvis Hip/Knee/Ankle/Foot Other_____

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

□ My Doctor_____ □ Another Healthcare Practitioner_____

□ Family/Friend _____ □ Internet Search: Google Yelp Facebook Other_____

□ West Seattle Community Shopper Ad □ Insurance Website _____

□ Other_____

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INSURANCE COMPANY INFORMATION AND/OR CLAIM INFORMATION

Name of insurance adjuster or contact *(if applicable)*:_____

Phone Number of adjuster or contact: _____ Claim Number: _____

Primary Insurance Company: _____

Identification Number: _____ Group Number: _____

Address: _____ City: _____

State:_____ Zip Code:_____ Phone:_____

Policyholder *(if other than patient)*:_____

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

Male / Female Phone *(of policyholder)*:_____ SSN: _____

Employer *(of policyholder)*:_____

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.

Authorized Signature: _____Date:_____

RECEIPT OF NOTICE OF PATIENT PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the notice of patient privacy practices, 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 Tricia Yost, DPT, LMP, OCS, Jennifer Howe, MPT, CMPT, Megan Sherman, DPT, Lauren Esmailka, DPT, COMPT, FAAOMPT, Robin Haven, DPT, and therapists filling in for 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 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 charge of 1% per month and may be sent to a collection agency.

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 will be **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 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 minimum fee of $50 and up to $100. This amount is not covered by insurance.** In addition, if you arrive more than 15 minutes past your scheduled appointment time, you may be asked to pay a percentage of your visit to cover the amount of time that cannot be billed to insurance.

****Please note, if you are an L & I patient, visits may only be 40 minutes as this is the maximum L & I will reimburse.**

1st Cancellation without 24-hr notice - no fee, forgiven.
2nd Cancellation without 24-hr notice - $50 fee.
3rd Cancellation without 24-hr notice - $50 fee. Future appointments cancelled. Can call in for same day appointments.

I understand that if I am late and/or am not able to give 24 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 your responsibility to know your insurance coverage and benefits.**

INSURANCE COVERAGE

At this time, Life in Balance Physical Therapy and Pilates, LLC is contracted with the following insurance companies: BCBS, Uniform (now Regence), Aetna, Medicare, First Choice Health Network, Cigna, Premera, Regence, Lifewise, L& I, PIP.

If you do not see your insurance provider listed above, you will need to call to find out if you have "out-of-network" benefits with a "non-contracted provider." We may verify your insurance benefits and give you the information that we received; however **quoted benefits are not a guarantee of payment.**

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

PATIENT PAYMENTS

Co-pays are expected at the time of service. Patients with a deductible will pay $100.00 per visit until their deductible is met. Payment is due at the time of service. Prepaid Co-insurance payments are highly recommended. Please let us know if you need a receipt and we will be happy to write one for you. Co-insurance amounts are fully calculated after your insurance has processed the claim. For information regarding this percentage, contact your insurance company. In addition, once the 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, bills to patients typically go out the first week of each month. If your claims have not yet processed through insurance, you will not be billed for your portion. The claims process typically takes an average of 30 days. Bills will reflect only the amount owed. **Your payment is due upon receipt of the statement. Patients carrying a balance greater than $300 will not be treated until their balance is paid in full.**

CASH PAY

Our cash pay rate is $125 per visit. Payment is due at time of service. This rate is already discounted.

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 are able to accept 3rd party PIP on a limited basis. So that we may be able to continue to offer this as a service to our clients, we require a minimum payment of $100.00 per visit at the time of service. At the time of your first visit, we will also need you to acquire a "letter of guarantee" from your attorney and understand that we will be unable to negotiate fees at the time of the settlement. All outstanding balances will be due 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: _____Job duties or restrictions: _____ Full/Part Time Off Work Y/N

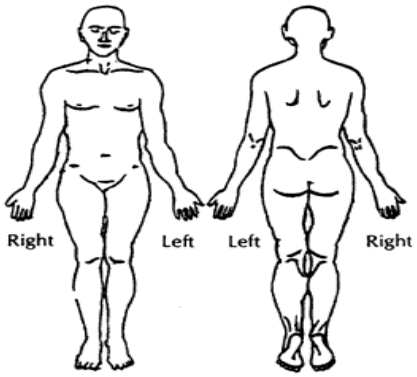
Describe your injury or symptoms:

_____

_____

_____

Mark areas of symptoms you may experience.



Circle today's level of pain:

0 1 2 3 4 5 6 7 8 9 10

I feel **BETTER** with _____

WORSE with:_____

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

Other: _____ **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

List pertinent surgeries or medical procedures: _____

MEDICATIONS: _____

What are your 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 therapy and exercise program for me.

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