Life in Balance Physical Therapy & Pilates, LLC

PATIENT INFORMATION Today's Date: ___________________

Last Name: _________________________ First Name: _______________________ MI: ___

Date of Birth: ___/___/_____ Male / Female Marital Status: Single Married Other

Home Address: ___________________________________ City: ______________ State: _____

Zip Code: _________ Home Phone: _________________ Cell Phone: ____________________

Social Security Number: ___________________ E-mail address: _______________________

How did you hear about us? ____

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

Employer Name/School Name: ____

Work Address: ___________________________________ City: ______________ State: _____

Zip Code: _______ Work Phone: _________________ Title/Position: ___________________

**Please indicate which phone number you would prefer to be used for patient- therapist contact: ___________________________

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.

REFERRING PHYSICIAN INFORMATION

Name: _________________________________ Phone Number: _______________________

Address: ____

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

Last Name: ________________________ First Name: _______________________ MI: ___

Home Address: __________________________________ City: _______________ State: _____

Zip Code: _______ Home Phone: __________________ Cell Phone: ___________________

Relationship: Spouse Parent Guardian Work Phone: _____________________________

REASON FOR TODAY'S VISIT

Is this injury/condition related to: your job an auto accident home accident other

Please indicate the date of your accident/injury: _____________________________________

Please indicate the date of your illness: ____

Please describe your injury / accident / illness: ______________________________________

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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:______________

AUTHORIZATION FOR TREATMENT

The undersigned hereby authorizes Tricia Yost, DPT, LMP, Jennifer Howe, MPT, CMPT, Megan Sherman, DPT, Christina Volckmann Perala, MSPT, and therapists filling in for Life in Balance Physical Therapy and Pilates, LLC to provide physical therapy and other therapeutic 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-on-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, L & I will only cover a 45 minute appointment.

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

Life in Balance Physical Therapy & Pilates, LLC

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 let us know if you have any questions.

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.

It is your responsibility to know your insurance coverage and benefits.
If you do not see your insurance provider listed here, 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 $65.00 per visit until their deductible is met. Payment is expected 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 bill is due upon receipt of the statement. Please be advised that unpaid bills may result in Life in Balance discontinuing treatment.

CASH PAY:
Cash pay patients receive a discount if payment is made at the time of service.

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 $65.00 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: ____________________________

Life in Balance Physical Therapy & Pilates, LLC

Medical History and Symptom Description

Name: ____ Age: ___________ Date: _______________________
Occupation: ____________________________________ Date of Injury or surgery: _______________________
Job duties or restrictions: _________________________ ☐ not working ☐ Part / Full time ☐ light / full duty

Draw the areas of pain, weakness, spasms, radiating pain, tingling, numbness or any other symptoms you may experience.

Describe your injury or symptoms:

____

____

____

____

____

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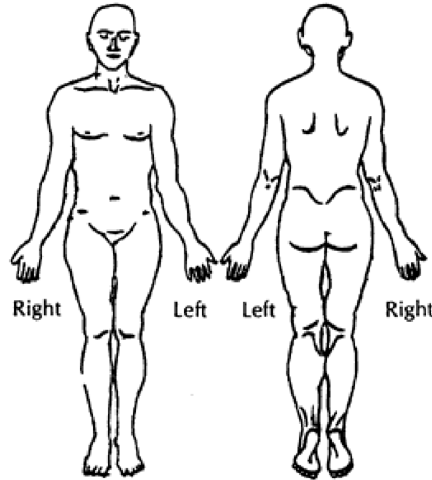

Circle today's level of pain	Best/No pain		Mild		Moderate		High		Severe		Unbearable
	0	1	2	3	4	5	6	7	8	9	10

I feel **BETTER** with: ________________________________ **WORSE** with: ____________________________________

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

Driving	Sleeping	Looking over shoulder	Computer Use/typing	Looking up or overhead
Grooming	Dressing	Reaching overhead	Reaching behind back	Reaching across body
Bending	Sitting	Standing	Lifting/carrying	Pushing or Pulling
Steps & Stairs: Up / Down	Walking	Squatting	Kneeling	Running or Jumping

Other: ____

Prior treatments and results: ____
Diagnostic Testing: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ NCV ☐ Other: ____________
Results: ____
Medical History: Please circle **ALL** that apply

Arthritis/DDD/DJD	Dizziness	Incontinence	Pregnancy	Smoking
Asthma	Fainting	Kidney disease	Psychological: (List)	Stroke/brain injury
Balance deficits/vertigo	Fractures: (Please list)	Liver disease	_________________	Weight gain/loss
Blood Pressure: Low/High	1. ________________	Lung/Pulmonary disease	Recent Illness: (please list)	Other: _____________
Blood Disorders	2. ________________	Respiratory	1. _________________	__________________
Cancer/Tumor	Heart Disease/Circulatory	Night time pain	2. _________________	
Diabetes	Headaches	Osteoporosis	Seizures	

List pertinent surgeries or medical procedures: ____
____
List pertinent MEDICATIONS: ____

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.

Signatures:
Patient / Guardian: ________________________________ **Therapist**: ________________________________

Life in Balance Physical Therapy & Pilates, LLC

Functional Survey

Mark your current status in these categories

WALKING TOLERANCE
- † No pain with walking
- † Can walk as much as I like but with increased pain
- † Can walk 1 mile
- † Pain walking hills
- † Can walk < ¼ mile
- † Leg symptoms with walking

SLEEP DISTURBANCE
- † No disrupted sleep
- † No disturbance, but increased pain upon awakening
- † Difficulty getting to sleep due to pain
- † Sleep disturbed 2-3 hours /night
- † Arm/hand numbness with sleeping

STAIRS
- † No pain with stairs
- † Pain/instability stepping on/off curb
- † More pain up stairs
- † More pain descending stairs

DRIVING
- † No pain with driving
- † Can drive as long as I want, but increased pain
- † Can drive < 30 minutes
- † Pain whenever I drive

SQUATTING
- † Pain with squatting
- † Noise with squatting
- † Pain getting in and out of car

WORK STATUS

Working:† Full time † Part time

† Light duty † Not working

Occupation:_________________________________

Work Duties:________________________________

- † No pain with work duties
- † Can work as much as I like but with increased pain
- † Modifying work due to pain
- † Not working due to pain

LIFTING

How much?___________________________________

How often?___________________________________

SITTING TOLERANCE
- † No pain with sitting
- † Can sit as long as I like but with increased pain
- † Time depends on chair
- † Pain with sitting < 15 minutes
- † Leg symptoms with sitting
- † Pain with sitting < 1 hour

STANDING TOLERANCE
- † No pain with standing
- † Pain with standing < 1 hour
- † Pain with standing < 15 minutes
- † Pain with standing at sink/counter
- † Pain standing after prolonged sitting

LIFTING TOLERANCE
- † No pain with lifting
- † Can lift but with pain
- † Can only lift light weight
- † Cannot lift at all

REACHING AND BENDING
- † No pain with reaching
- † Pain reaching overhead
- † Pain reaching across back
- † Pain reaching across body
- † Pain when bending over
- † Pain when twisting and leaning back

OTHER ACTIVITIES

Sport/recreational activities

____

Able to do these activities?

____

Regular cardio-vascular or walking program?

____

How many times a week?

____

Gym program and how many times a week?

____

Pain with housework?

____

Pain with yard work?

____

† Raking † Shoveling † Mowing † Weeding † Planting

YOUR GOALS FOR RECOVERY ARE?

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____

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