VILLAGE
PHYSICAL THERAPY
5234 50th Avenue NE | Seattle, WA 98105
P 206-498-8496 | F 206-527-6501

REGISTRATION FORM – PAGE 1

(Please Print)

DATE:_____

LAST NAME		FIRST NAME	MI
ADDRESS		CITY STATE	ZIP
HOME PHONE		CELL	WORK
EMAIL		AGE	BIRTHDATE
GENDER	MARITAL STATUS		ARE YOU PREGNANT? YES ☐ NO ☐ N/A ☐
REFERRING DOCTOR		MD FAX	MD PHONE
WAS THIS A JOB RELATED OR AUTO ACCIDENT? YES ☐ NO ☐			DATE OF ACCIDENT
REASON FOR TODAY'S VISIT			
HOW DID YOU HEAR ABOUT VILLAGE PHYSICAL THERAPY?			
OCCUPATION			EMPLOYED? YES ☐ NO ☐

EMERGENCY CONTACT INFORMATION

NAME	PHONE	RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE	ID #	GROUP #
INSURED NAME	BIRTHDATE GENDER:	RELATIONSHIP
INSURED EMPLOYER		
SECONDARY INSURANCE	ID #	GROUP #
INSURED NAME	BIRTHDATE GENDER:	RELATIONSHIP

IF L&I CLAIM

CLAIM #	DATE OF INJURY
CLAIM MANAGER	CLAIM MGR PHONE

IF MOTOR VEHICLE ACCIDENT

CLAIM #	DATE OF ACCIDENT
CLAIM MANAGER	CLAIM MGR PHONE

FINANCIAL AGREEMENT: I understand, as the patient and/or above-mentioned responsible party that I am fully responsible for payment of all charges incurred. I authorize my insurance benefits to be paid directly to Village Physical Therapy, LLC for services rendered. I understand I am financially responsible for any deductibles, co-pays, co-insurance, non-covered services, or non-authorized services. I authorize Village Physical Therapy, LLC to release any information requested by the insurance company with regards to payment of benefits.

Signature:_____ Date:_____

I am aware of the cancellation / no show policy of Village Physical Therapy, LLC which reserves the right to charge a patient who fails to keep a scheduled appointment or cancels with less than 24 hours notice. This fee of $50 cannot be billed to the insurance company.

_____ (Initials)

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REGISTRATION FORM – PAGE 2

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Medical History

Name: _____ Date: _____

What is your primary problem? _____

Secondary problems? _____

How did your problems begin? _____

_____ When? _____

What is your occupation? _____

Are your problems work related? ☐ Yes ☐ No

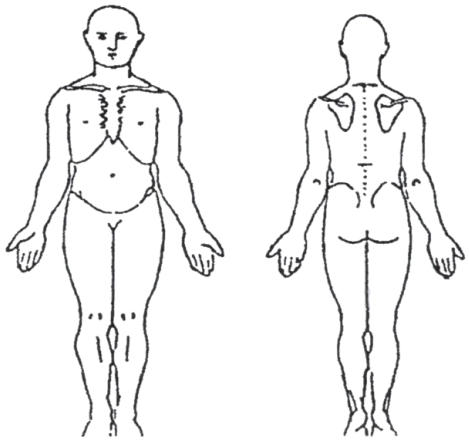
What makes your pain worse? _____

What eases your pain? _____

Can you get comfortable at night? ☐ Yes ☐ No

How do you feel upon rising in the morning? ☐ Stiff ☐ Sore ☐ Fine

What is it like at the end of the day? ☐ Worse ☐ Easier



Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO		YES	NO
Allergies	☐	☐	Depression	☐	☐	Multiple Sclerosis	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐
Anxiety	☐	☐	Dizzy Spells	☐	☐	Parkinsons	☐	☐
Arthritis	☐	☐	Emphysema/Bronchitis	☐	☐	Rheumatoid Arthritis	☐	☐
Asthma	☐	☐	Fracture	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Gallbladder Problems	☐	☐	Speech Problems	☐	☐
Cardiac Conditions	☐	☐	Hepatitis	☐	☐	Strokes	☐	☐
Cardiac Pacemaker	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chemical Dependency	☐	☐	Incontinence	☐	☐	Tuberculosis	☐	☐
Circulation Problems	☐	☐	Kidney Problems	☐	☐	Vision Problems	☐	☐
Currently Pregnant	☐	☐	Metal Implants	☐	☐			

Describe any other conditions or precautions:

FALL HISTORY

	YES	NO
Injury as a result of a fall in the past year?	☐	☐
Two or more falls in the last year?	☐	☐

SURGICAL HISTORY

Body Region: _____ Surgery Type: _____ When: _____/_____/_____

CURRENT MEDICATIONS

Please list the medications you are currently taking. If you have a printed list available, we can also copy it for you.

Medication 1: _____ Dosage: _____ Reason: _____

Medication 2: _____ Dosage: _____ Reason: _____

Medication 3: _____ Dosage: _____ Reason: _____

Medication 4: _____ Dosage: _____ Reason: _____

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CONSENT FOR CARE AND FINANCIAL AGREEMENT

Consent for Care & Treatments

I, the undersigned, grant permission for licensed physical therapists at Village Physical Therapy, LLC to perform such examinations and therapeutic procedures as may be professionally deemed necessary or advisable for appropriate evaluation and treatment of my condition.

Release of Information

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s), my insurance company at their request, and other healthcare providers as may be necessary for communication regarding my care. Additionally, I authorize the following individuals to have access to my health information:

NAME: _____ **NAME:** _____

Financial Policy

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance carrier requests a full refund of payment made, you will be responsible for the amount of money refunded to your insurance carrier. If any payment is made directly to you for services billed by us, you recognize an obligation promptly remit same to Village Physical Therapy, LLC.

The above does not apply to those patient's that are considered Workers Compensation, however be advised if you claim workers compensation and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collection monies owed, including court costs, collection agency fees and attorney fees.

I understand that all Co-pays are due at the time of service.

Cancellation Policy

The patient is responsible for keeping all scheduled appointments, and for arriving on time. We require 24 hours notice for cancelled appointments. Patient's arriving late may have their treatment time adjusted accordingly. Two consecutive No-Show appointments will result in future scheduled appointments being cancelled. You are responsible for verifying with your insurance company physical therapy benefits/coverage.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND HAVE READ AND UNDERSTAND MY PRIVACY RIGHTS AND PRACTICES.

SIGNATURE:_____ **DATE:**_____