501 S. Bernard St. Spokane, WA. 99204
Phone: (509) 701-7651   Fax: (509) 279-2636

NEW PATIENT INFORMATION FORM

Name: ____Date:__________________
Gender assignment for insurance purposes: ☐ Female ☐ Male
First M.I. Last

Date of Birth:_________________________ Phone :_________________________

Email: ____
Appointment Reminders? ☐ Text ☐ Email

Address:____

City, State, Zip : ____

EMERGENCY CONTACT

Name: ____ Phone #: __________________

Relationship to Patient: ________________

Referring doctor : _____________________________ Phone #:____________________

Primary Care Doctor:____

How did you find out about us?____

MEDICAL HISTORY

What are you primarily being seen for?
(concussion, dizziness, anxiety/depression, sensory processing, pain)

____

____

List treatment, therapy, and/or imaging you have received for the primary concern above?

____

____

____

Medical History:

Diagnosis	Medication (if any)

Let us know of any precautions we should be aware of (allergies, seizures, cardiac or respiratory issues, communicable illnesses, history of falls):

____

____

What are your goals for therapy?

____

____

____

HIPAA

I consent to the use or disclosure of my protected health information (PHI) by Inland Empire Therapy Associates, LLC DBA Empire Therapy, for the purpose of Treatment, Payment, and Health Care Operations. I have read a copy of the Notice of Privacy Practices: HIPAA and understand I have a right to review it prior to signing this document.

Patient Name: ____

Patient Signature__________________________________

Date: _______________

INFORMED CONSENT FOR THERAPY SERVICES

Occupational/speech/physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of occupational/speech/physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to occupational/speech/physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Inland Empire Therapy Associates, DBA Empire Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the speech/occupational/physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your speech/occupational/physical therapist about the treatment they have planned based on your individual history, speech/occupational/physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in receiving occupational/physical therapy and agree to fully cooperate, participate in all therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

"Consent" means that: (1) You have been fully informed of all information relevant to the activity(ies) for which consent is sought in your native language (unless clearly not feasible to do so) or mode of communication including sign language, Braille or oral communication as appropriate, (2) that you understand and agree in writing to the carrying out of the activity(ies) for which consent is sought, (3) the consent describes the activity(ies) and lists the early intervention records (if any) that will be released and to whom they will be released and (4)the granting of your consent is voluntary and may be revoked in writing at any time. If you revoke consent, it is not retroactive (it does not apply to an action that occurred before the consent was revoked).

Patient Name____

Patient Signature________________________Date:_____________

INSURANCE INFORMATION	**SECONDARY INSURANCE INFO.**
Primary Insurance Co:____________________	2nd Ins Co:________________________
I.D.# ________________________	I.D.#________________________
Group#________________________	Group#________________________
Subscriber Name to insurance:______________	Subscriber Name:___________________
Subscriber Employer:____________________	Subscriber Employer:________________
Subscriber Date of Birth:__________________	Subscriber D.O.B.:__________________
Relationship to Patient:__________________	Relationship to Patient:_______________

Billing: Empire Therapy is committed to providing only the highest quality therapy for you. Please note, insurances do not pay for all therapy costs. Some services and diagnosis' are not considered "covered benefits" under every health insurance plan. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance will be your responsibility. All co-pays must be paid at the time of service. All deductibles, co-insurances, or other patient responsibility balances will be invoiced directly to your email on file after your insurance has processed your claims accordingly. Invoices are due within 30 days from the date of the invoice.

By signing below, you acknowledge that you have been informed in advance of receiving therapy services, that your health insurance may not cover all costs. You acknowledge that you understand your specific insurance plan/benefits, including all out of pocket expenses. You are choosing to receive these services and understand that you are financially responsible for all balances stated in this letter.

Patient Signature________________________Date________________

ATTENDANCE/CANCELLATION POLICY

At Empire, we strive to provide the best therapy for all of our patients. In order to reach each person's therapy goals, it is invaluable that we have consistent attendance to appointments, as well as a strong home program implemented by caregivers.

Please **sign below** that you have read and understand our cancellation/no show policy, as well as our 85% attendance rate requirement.

We understand that sometimes you need to cancel or reschedule your appointment last minute due to an emergency or illness. If you are unable to keep your appointment, we ask that you please call us as soon as possible so that we can fill that spot.

All other cancellations require a 24-hour notice in order to reschedule or cancel your appointment but please call as soon as possible since the more notice we have the more likely we can fill the spot from our call-in list.

Late cancellations, without valid reason, or no show appointments will be charged a fee of $70. If this is your first late cancellation/no show, you will receive a one-time waiver of your fee as a reminder of our attendance policy. Being sick is a valid reason to cancel an appointment. Once two fees have been issued, you will be removed from the schedule and will be moved to a call-in basis. You will need to call us on the day you wish to receive therapy to see if there is an opening available.

Our 85% attendance rate requirement means that you must attend a minimum of 85% of your appointments over a three month span. This includes all no shows, last minute cancellations, and 24-hour cancellations. The exception is if a cancellation is rescheduled for another appointment time.

If you are scheduled for two appointments per week and are not maintaining an 85% attendance rate, then you will be provided with one appointment per week. If you are scheduled for one appointment per week, you will be moved to a call-in basis which means your regularly scheduled appointments will be given to a child on the wait list. After consistent attendance to four call-in appointments, you may request to be added to the top of the waitlist for a full time spot on the schedule.

We know that life happens and exceptions will be made in extraordinary circumstances. Our intention is not to penalize families, but to help all of our patients reach their goals for physical, social, and emotional well-being. If you have any questions about our policy, please do not hesitate to talk with your therapist or call us at 509-701-7651.

Patient Signature________________________________Date__________

OUT OF POCKET EXPENSES

Our goal at Empire is to always provide the best quality therapy at a reasonable, competitive price for our patients. We make every effort possible to keep our costs low while maintaining our high level of care. In the process of keeping costs low, we like to make sure our patients understand their insurance and expected out of pocket expenses. The following will go over estimated costs of out of pocket expenses:

* Empire bills out the following (applicable to your deductible):

OT/PT/ST Eval: $200 OT/PT Visit: $130 ST Visit: $90

Reminder: Co-pays are due at the time of service. It is your responsibility to pay this at every visit. We will do our best to give you an estimation of the co-pay amount and remind you at your appointment to make this payment. If you forget to pay at the visit, this will be billed to you.

Subscriber Name: ____

Insurance name and date verified: _______________________________

Deductible: ____

Out of Pocket Maximum: ____

Co-Pay: ____

Co-Insurance %: ____

Authorized Visits: ____

Please note, this is an estimation of your expected out of pocket costs, given to you as a courtesy - this is not a quote or guarantee of the amount your insurance will cover. By signing below and/or receiving therapy from Empire, you agree to understand your out of pocket expenses, agree to pay your co-pay at the time services are rendered and agree to pay the remaining expenses (deductible/ co-insurance) within 30 days of your invoice date.

Patient Name: ____

Patient Signature: ____ Date: __________