PHYSICAL THERAPY PATIENT INFORMATION

Print, complete and send via fax or scan/email to below listed contact information.

Lagniappe Physical Therapy and Pilates
5727 Baker Way NW Suite 203, Gig Harbor, WA 98332
email: lagniappeptpilates@gmail.com
Fax: 318-302 0140 (Attn: Ashley Pittman)
Tel: 253-244-3465

Patient Name_________________________________Birthdate_______________ Age _______

Patient Address ____________________________City/State/Zip_________________________

Home telephone ________________________Cellphone ______________________________

E-mail ____

Preferred way to contact you? Circle one: home phone cell phone e-mail

PAYMENT POLICY

Lagniappe PT and Pilates is a now a participating provider with Medicare, Regence BlueShield, Aetna, Cigna and First Choice Health Network. Patients will be responsible for unmet deductible, copayments and/or coinsurance at time of service. Please contact your insurance provider to understand your benefits.

Currently we are credentialing with other insurance providers, but considered out of network at this time. Patients will be responsible for complete payment at each visit.

Forms of payment: Payment may be made by check, cash, Visa, Mastercard, American Express or Discover. (make checks payable to Ashley Pittman or Lagniappe, PLLC)

Cancellation policy: Patients will be charged $50 for failure to show and $ 25 for late cancellations (less than 24 hours). Please call to reschedule/cancel as soon as you know you will not make your appointment time. Please consider this when scheduling your appointment as this allows therapist to schedule 1 on 1 treatments with patients. 3 consecutive “no shows” will result in a discharge from PT services.

Responsibility for payment

Responsible party (if other than patient) ____

Email or home address where invoices should be sent: ___________________________

Insurance carrier ______________________________ Member ID___________________

Phone # (on back of card)____

Guarantor name (if not patient) ________________________ DOB ____/___/________

Secondary insurance (if applicable)______________________ Member ID ____________

MEDICAL HISTORY

Please include your preferred physician for following our plan of care, updates, etc.

Physician _____________________________________

Specialty______________________________________

Office telephone ________________________________

If prescribing physician is not your primary care doctor, please provide:

Primary care physician (pediatrician or internist) _________________________________

Office address (city & state)____

Office telephone ___________________website, if any ____________________________

Date of most recent spinal x-rays (if known) ________________

Return MD visit ___________________________

Any significant medical episodes or ongoing conditions (if no longer present, give dates or age when present and how resolved)____

____

____

____

____

Pertinent family history of illness ____

____

____

Treatments to date ____

____

____

Previous Pilates or other exercise program _____________________________________

____

Any surgeries (give dates or age)____

____

____

Medications currently taken (separate sheet if needed) ___________________________

____

Occupation ________________________________

CURRENT CONDITION

Pain: where does it hurt? ____

When did it start-- date or age? ____

How did it start -- was it gradual or sudden? related to a particular event? _________________

____

____

Rate the pain on a scale of **0 to 10**, 10 being the worst

Typical pain level this past week _________ Worst pain this past week _________

Is it constant or does it vary with activities? ____

____

Any other symptoms such shortness of breath, numbness, tingling, other (what brings it on?)

____

____

Activities and hobbies (include brief job description, exercise and dance, musical instruments, any physical activity you engage in with some regularity) ______________________________

____

____

____

Activities which are difficult or impossible because of pain or other symptoms

____

____

____

GOAL for physical therapy What do you hope to get from physical therapy?

patient: ____

____

How did you hear about us?

____

Patient signature (parent/guardian if patient is a minor) _______________________________

Person completing this Medical History ____

Relationship to patient ____ Date ___________

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.

• You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

• You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Lagniappe, PLLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (parent or guardian if patient is under age 18) understands that:

• Protected health information may be disclosed or used for treatment, payment, or health care operations.

• Lagniappe, PLLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

• Lagniappe, PLLC reserves the right to change the Notice of Privacy Practices.

• The patient has the right to restrict the uses of their information but Lagniappe, PLLC does not have to agree to the restrictions.

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

• Lagniappe, PLLC may condition receipt of treatment upon the execution of this consent.

• The patient (parent or guardian if patient is under age 18) acknowledges that he/she has received a copy of our HIPAA Notice of Privacy Practices as available in person upon request.

My signature below indicates my consent.

This consent is signed by ____

Print name here: ______________________________________ Date: _______________________

Relationship to Patient (if other than patient): ____

Privacy Practice

Check all that apply

- ☐ I give Lagniappe, PLLC (Ashley Pittman) the right to phone, text or email to confirm appointments
- ☐ I give Lagniappe, PLLC (Ashley Pittman) the right to leave a detailed message on the voicemail/answering machine of phone number provided.
- ☐ I give Lagniappe, PLLC (Ashley Pittman) the right to leave a detailed message on the email provided.
- ☐ I give Lagniappe, PLLC (Ashley Pittman) the right to discuss medical and/or financial information with the following people:

____

________________________________ ________________________
Sign **Date**

____
Print

Photo/Material Release

At Lagniappe Physical Therapy and Pilates (Lagniappe, PLLC), we want to make sure every patient understands information gathered may be used for educational and/or research purposes. Additionally, there are other opportunities to share success through marketing, etc.

I authorize the use of any photos or material taken and/or given to be used at the therapist's discretion for:

- ☐ Marketing purposes
- ☐ I can decide later
- ☐ No, thank you

Patient: ____ Date: ____________