REGISTRATION FORM – PAGE 1

(Please Print)

5417 Ivanhoe Place NE, Seattle, WA 98105
P 206-498-8496 • F 206-527-6501 • www.VillagePTSeattle.com

DATE:___________________

LAST NAME	FIRST NAME	MI
ADDRESS	CITY	STATE ZIP
HOME PHONE	CELL	WORK
EMAIL	AGE	BIRTHDATE
SEX: M F / 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 SEX: M F	RELATIONSHIP
INSURED EMPLOYER		
SECONDARY INSURANCE	ID #	GROUP #
INSURED NAME	BIRTHDATE SEX: M F	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)

REGISTRATION FORM – PAGE 2

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Medical History

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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

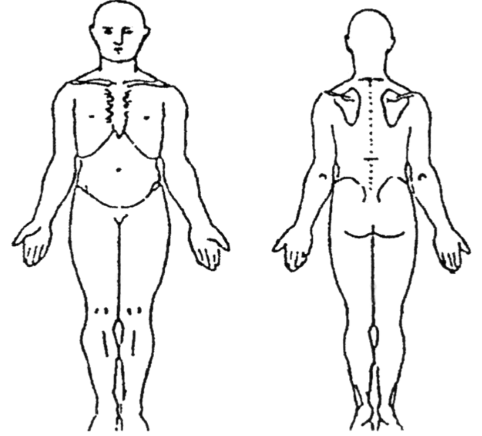
What makes your pain worse? ______________________________

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: ______________

09/2012

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REGISTRATION FORM – PAGE 3

(Please Print)

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:

____________________________________ ____________________________________

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:**______________________

09/2012