North Tacoma
5701 N. 26th Street
Tacoma, WA 98407
P: (253) 507-7450
F: (253) 507-7572

ELITE Physical Therapy
www.eliteptwa.com

Spanaway
223 140th St South
Tacoma, WA 98444
P: (253) 531-5645
F: (253) 536-3467

PATIENT INFORMATION

Name: _____ ☐M ☐F Height: ____ Weight: ____ DOB: _____

SSN: _____ Address: _____

Home Phone: _____Cell Phone: _____Referring MD_____

Employer/Phone: _____

Emergency Contact: _____ Phone: _____ Relation:_____

How did you hear about us? ☐ Internet ☐ Friends/Family ☐ Physician Office ☐ Other_____

Is there anyone that you would like your personal health information shared with? (Spouse, Family member, Physician (other than referring doctor), etc) Please list names. _____

_____

Primary Insurance Company:_____ ID#:_____

Group Name: _____ Group # _____

Secondary Insurance Company:_____ ID#:_____

Group Name: _____ Group # _____

CONSENT TO TREATMENT

I hereby consent to treatment by the authorized personnel of Elite Physical Therapy 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.

Patient Signature: _____ Date: _____

POLICIES

Insurance Information: To assist us in billing your insurance company, please provide us with your insurance card and any additional information we may need. We recommend you call your insurance company to verify your physical therapy coverage, as it is your responsibility to know your policy benefits and limitations.
Payment Options: We accept personal checks, credit card, and cash. **Insurance co-payments are due at each visit.**
Pet Policy: No pets will be allowed in the building unless documentation of medical necessity is presented.
Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability or age. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 protect all clients who come to our clinic for services.
Cancellation Policy/No Show Policy: We are happy to reschedule your appointments when a conflict occurs with notice of 24 hours. If less than 24 business hours notice is given **you will be charged a $40 late cancellation fee**. If no cancellation notice is **given you will be charged a $40 no show fee and all remaining appointments will be cancelled**. The patient is financially responsible for charges incurred from late cancellations or no shows and fees accrued at Elite Physical Therapy **will not be charged to my insurance company**.

Patient Signature: _____ Date: _____

Thank you for allowing us the opportunity to serve you. If you have any questions please do not hesitate to ask.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ELITE PHYSICAL THERAPY'S LEGAL DUTY

Elite Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Elite Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Elite Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Elite Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, Elite Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Elite Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment, any administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Elite Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you have a complaint, are concerned that Elite Physical Therapy may have violated your privacy rights, disagree with any decisions we have made regarding access or disclosure of your personal health information, or you would like further information on Elite Physical Therapy's health information practices please contact our office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

ASSIGNMENT OF BENEFIT

I hereby assign all medical benefits to which I am entitled to Elite Physical Therapy in the event they file insurance on my behalf. As the responsible party, I understand that I am financially responsible for all charges not directly paid by my insurance company. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. If my Insurance changes in any way it is my responsibility to inform Elite Physical Therapy of this change prior to the change occurring. Failure to do so may result in a bill for outstanding charges for physical therapy/massage therapy treatments. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

PATIENT INFORMATION CONSENT

I have read and fully understand Elite Physical Therapy's Notice of Information Practices. I understand that Elite Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Elite Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the disclosure of my personal health information for purposes as noted in Elite Physical Therapy's Notice of Information Practices. I also understand I retain the right to revoke this consent by notifying the company in writing.

Patient Signature: _____ Date: _____

Health Questionnaire

Please rate your pain from a 0 to 10:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

At best, pain is_____ At worst, pain is_____

On average, pain is_____

When did the pain start? _____

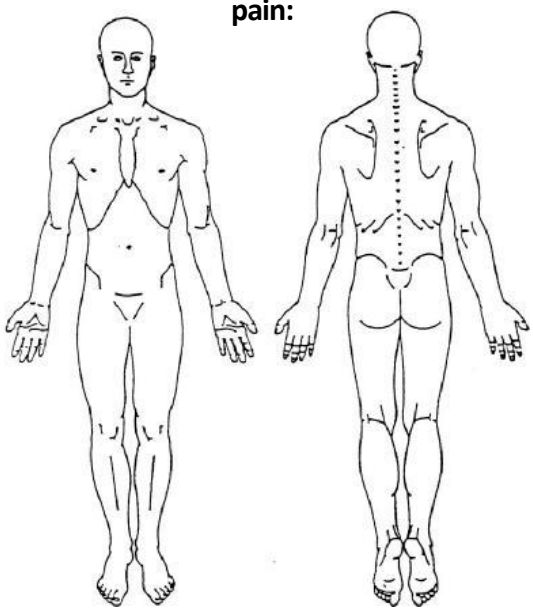
Is the pain getting:

☐ Worse ☐ Better ☐ Unchanging

Check description of pain:

- ☐ Sharp
- ☐ Ache
- ☐ Numb
- ☐ Pull
- ☐ Dull
- ☐ Heavy
- ☐ Tight
- ☐ Burn
- ☐ Tingle
- ☐ Throbbing
- ☐ Shooting
- ☐ Stabbing

Mark location(s) of pain:



Functional Limitations:

_____

_____

_____

_____

Do you have a history of:

Cancer	**YES**	**NO**
Diabetes	**YES**	**NO**
High Blood Pressure	**YES**	**NO**
Chest Pain	**YES**	**NO**
Heart Complications	**YES**	**NO**
Stroke	**YES**	**NO**
Osteoporosis	**YES**	**NO**
Arthritis	**YES**	**NO**
Joint Replacement	**YES**	**NO**
Kidney Disease	**YES**	**NO**
Rheumatic Disease	**YES**	**NO**

Are you experiencing:

Changes in General Health	**YES**	**NO**
Nausea/Vomiting	**YES**	**NO**
Fever/Chills/Night Sweats	**YES**	**NO**
Unexplained Weight Change	**YES**	**NO**
Appetite Changes	**YES**	**NO**
Difficulty Swallowing	**YES**	**NO**
Bowel/Bladder Changes	**YES**	**NO**
Shortness of Breath	**YES**	**NO**

Are you currently:	**YES**	**NO**
Pregnant	**YES**	**NO**
Depressed		

Do you:

Smoke	**YES**	**NO**	How much? _____
Drink	**YES**	**NO**	How much? _____
Exercise	**YES**	**NO**	How much? _____

Medication	Dosage	Frequency	Route

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0___. 1___. 2___. 3___. 4___. 5___. 6___. 7___. 8___. 9___. 10___. Worst Disability

Name:_____