QUEST *Physical Therapy*

Issaquah, WA

IF PATIENT IS UNDER 18 YEARS OFAGE A LEGAL GUARDIAN MUST SIGN ALL PAPERWORK

Name_____ Date of Birth_____
LAST FIRST M.I.

Address_____ Gender_____

_____ E-mail_____
CITY STATE ZIP APPOINTMENT REMINDER? ☐ TEXT MESSAGE ☐ EMAIL

Primary Phone (_____) _____ Secondary Phone (_____) _____
☐ CELL ☐ HOME ☐ WORK ☐ CELL ☐ HOME ☐ WORK

Employer_____ Occupation_____

Employment: ☐ Full-time ☐ Student ☐ Retired ☐ Unemployed Other:_____

Emergency Contact_____ Relation_____ Phone (_____)_____

How did you hear about us? _____

Reason For Your Visit

Brief Description _____ Date of Injury/Surgery_____

Referring Physician _____ Date of Next Visit _____

Primary Care Physician _____ Date of Last Visit _____

Insurance Information

Primary_____ ID# _____ Group# _____

Office Use: Deductible _____ Copay:_____ Coinsurance:_____ Visit Limit:_____ Rx Y N Effective Date:_____ Spoke w/:_____

Secondary _____ ID# _____ Group# _____

Office Use: Deductible _____ Copay:_____ Coinsurance:_____ Visit Limit:_____ Rx Y N Effective Date:_____ Spoke w/:_____

_____ By initialing here you acknowledge that your insurance benefits have been provided as a **courtesy and not a guarantee** of benefits and/or coverage.

(OFFICE USE ONLY- Medicare Cap Amt Used_____)

Is anyone other than the patient the main policy holder in the primary or secondary insurance? If yes, please indicate for which insurance: ☐ primary ☐ secondary and complete the subscribers information below.

_____ Relation_____Date of Birth _____
LAST FIRST M.I.

Accident Type, If Applicable: ☐ Auto Accident ☐ Work Related Accident ☐ Other Accident_____

Name of Insurance _____ Adjusters Name _____

Claim/Policy# _____ Phone (_____) _____ Date of Accident _____

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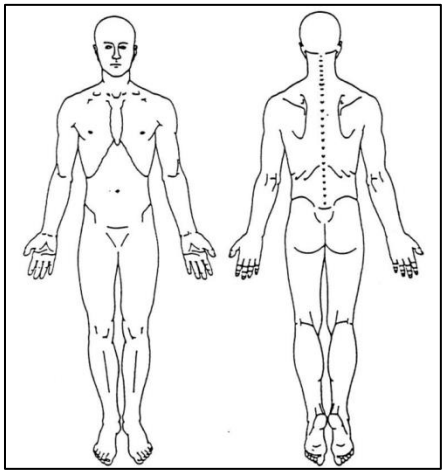
1. On the body diagram located to the right, indicate painful and/or injured areas which you are experiencing with a circle or other mark

2. Are your symptoms ☐ Improving ☐ Worsening or ☐ Same

3. The number line below is a pain assessment scale. Please use this to answer the following questions pertaining to your pain level.
   a. Currently: _____/10
   b. At best (in the past week): _____/10
   c. At worst (in the past week): _____/10



0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild, Annoying Pain		Nagging, Uncomfortable Troublesome Pain			Distressing Miserable Pain		Intense Horrible Dreadful Pain		Unbearable Excruciating Pain

4. What activities/positions **increase** your pain?

   _____

   What activities/positions **decrease** your pain?

   _____

5. How many days a week do you perform physical activity? _____ Type(s) _____

Please circle which of the following you have or have had in the past

Asthma	Heart Surgery	Seizure/Epilepsy	Arthritis
Emphysema	Weakness	Weight Loss/Fatigue	Osteoporosis
Headaches – Freq:_____	Stroke	Congestive Heart Failure	Gout
Shortness of Breath	Liver Dysfunction	Hernia	Broken Bones/Fractures
Chest Pain	Joint Replacement	Blood Clot/Emboli	Pain with Sneezing
Visual Difficulties	Cancer	Varicose Veins	Pregnant Current/Past
Hearing Difficulties	Head Injuries	Latex Sensitivities	C-Section
Heart Disease/Attack	Neurological Deficits	Allergies to Tape/Lotion	Depression
Pacemaker	Metal Implants	Thyroid Disease	Hypoglycemia
Dizziness or Fainting	Tobacco	Anemia	Fibromyalgia
High Blood Pressure	Kidney Dysfunction	Infectious Disease	Chronic Pain
Bowel/Bladder Issues	Eating Disorder	Type 1 or 2 Diabetes	Incontinence/ Leaking Urine

Please list past surgeries in related areas and their corresponding dates:

_____

_____

Current Medications *REQUIRED if you have Medicare insurance*: _____

_____

Is there any other information you would like to add regarding your medical history?

_____

_____

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Consent for Treatment

I, _____ give my consent for Quest Physical Therapy, LLC to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

Financial Policy Statement

Quest Physical Therapy, LLC will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. By signing below you authorize your insurance provider to pay Quest Physical Therapy directly. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance per your insurance contract. Copays are always due at the time of service as described in your insurance policy**.**

Billing Policy

As a courtesy our office will verify your insurance benefits, but this is not a guarantee. It is the patient's responsibility to confirm benefits with their insurance company.

Cancellation/No Show Policy

- Appointments scheduled represent time set aside specifically for you. All cancellations must be made at least **24 business hours** prior to the scheduled visit. (**This means that we need to hear from you no later than Friday if you need to cancel an appointment scheduled on Monday).** Patients who cancel or no-show on three separate occasions will be allowed to schedule additional appointments only at the discretion of their physical therapist.
- By Law, all cancellations and no-shows involving worker's compensation claims must be reported to your physician and your claims adjuster.
- **All cancellations (less than 24 hours) and no-show appointments will be charged a fee of $40.00 to your account. This fee is due before or at the time of your next physical therapy visit.**

Balances Owed

- Balances unpaid after 30 days will accrue a $25.00 fee for each billing cycle.
- Balances unpaid after 60 days must have payment arrangements with our office.
- Balances unpaid after 91 days will be turned over to our collection agency.
- Checks returned with non-sufficient funds will be charged a $35.00 fee.

I understand and agree to the Consent for Treatment, Financial Policy, Billing Policy, Cancellation Policy and Balances Owed Statements. I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with Quest Physical Therapy, LLC.

PATIENT OR GUARDIAN SIGNATURE DATE

E-mail Privacy Statement

Quest Physical Therapy's therapists like to stay in close contact with patients. We will be using e-mail at times during your treatment to send pertinent information regarding your account, recovery and progress. Our office is committed to your privacy and will not sell, disseminate, or give your email address to third parties.

Information Privacy Statement

Quest Physical Therapy, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed notice of privacy practices to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

Please include below the named person(s) with whom QUEST Physical Therapy, LLC are allowed to discuss your billing information and or condition.

NAME	RELATION
NAME	RELATION
NAME	RELATION
NAME	RELATION

I understand and agree to the E-mail Privacy, Information Privacy Statements.

PATIENT OR GUARDIAN SIGNATURE DATE