

Directions to S T R E T C H Physical Therapy

From I-5 Southbound:

Take the Stewart St/Denny Wy. Exit (#166) and immediately turn right onto John St. The next street is Yale Ave N, and we are located on the corner across from REI.

From I-5 Northbound:

Take the Mercer St./Seattle Center Exit (#167). Stay in the left lane and take a LEFT onto Fairview Ave. Take another left onto John St and follow that to Yale Ave N.

Parking:

Street metered parking is available, as well as the Alley 24 parking garage located just past our clinic on John St. We can validate parking for **One hour**, every hour beyond that is three dollars.

S T R E T C H

201 Yale Avenue North

Seattle, WA 98109

(206) 624-7602

(206) 624-7606 fax

STRETCH

Physical Therapy

DATE _____

PATIENT INFORMATION:

FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

PHONE (home) _____ (cell) _____ (work) _____

DATE OF BIRTH _____ SS# _____

EMPLOYER _____

WORK ADDRESS _____

EMAIL ADDRESS _____

REFERING DOCTOR INFORMATION:

DR'S NAME _____

ADDRESS _____ PHONE _____

DATE OF INJURY/SURGERY/FIRST SYMPTOM _____

INSURANCE INFORMATION:

INSURANCE COMPANY NAME _____

SUBSCRIBER ID # _____ GROUP NUMBER _____

CLAIMS ADDRESS _____ PHONE _____

SUBSCRIBER NAME _____ DOB _____ EMPLOYER _____

YOUR RELATIONSHIP TO INSURED ___ SELF ___ SPOUSE/PARTNER ___ CHILD

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME _____

SUBSCRIBER ID# _____ GROUP NUMBER _____

CLAIMS ADDRESS _____ PHONE _____

SUBSCRIBER NAME _____ DOB _____ EMPLOYER _____

YOUR RELATIONSHIP TO INSURED ___ SELF ___ SPOUSE/PARTNER ___ CHILD

By signing below, I understand that I am responsible for any and all charges that are unpaid by my insurance, and that late fees/interest may apply to any charges over 30 days old on my account

PATIENT/PARENT/GUARDIAN SIGNATURE _____

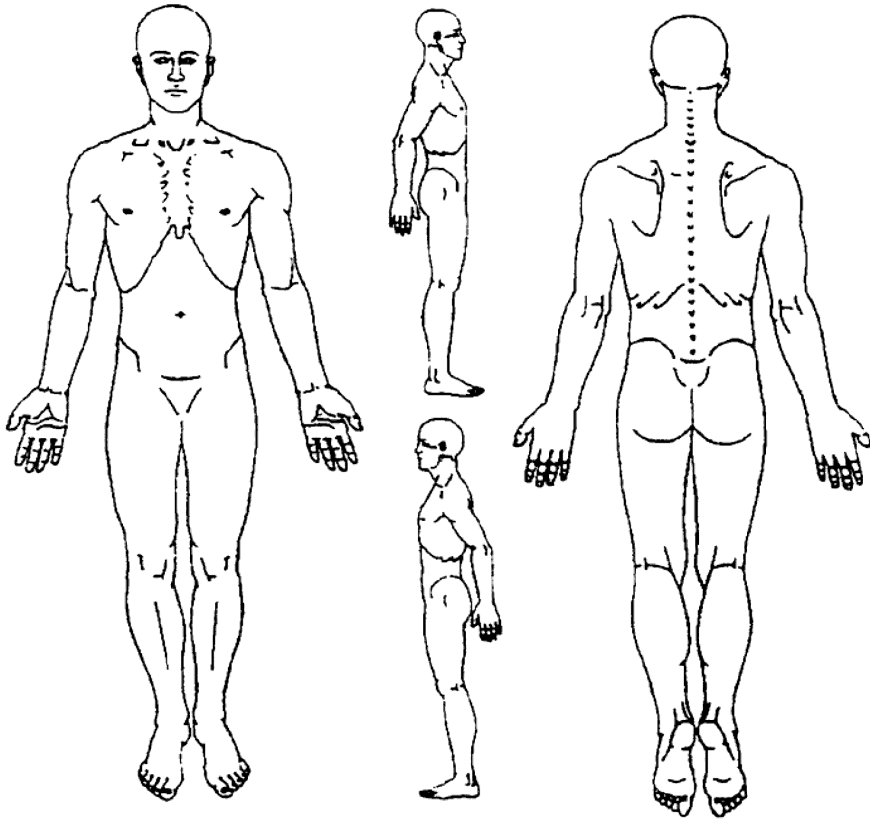
STRETCH Physical Therapy

Patient Name:		Today's Date:
Age:	Occupation:	Reason for Visit:
Date of Onset/Surgery:		Any Previous Treatment:
Was Previous Treatment Helpful?		

Describe details of accident/injury: _____

High Blood Pressure	Yes	No	Sensitive to Heat/Ice	Yes	No	Nervous Disorder	Yes	No	Other: _____ _____ _____ _____
Heart Disease	Yes	No	Allergies	Yes	No	Hearing Problems	Yes	No	
Heart Attack	Yes	No	Hernia	Yes	No	Cancer	Yes	No	
Pacemaker	Yes	No	Seizure	Yes	No	Insomnia	Yes	No	
Diabetes	Yes	No	Metal Implants	Yes	No	Depression	Yes	No	
Headaches	Yes	No	Dizzy Spells	Yes	No	Kidney Problems	Yes	No	
Balance Problems	Yes	No	Exercise: _____X/Wk	Type of Exercise: _____					

Please use the diagram on the right to mark all places you are currently having pain.



Please RATE your pain level: No pain 1 2 3 4 5 6 7 8 9 10

What eases the symptoms? _____

What aggravates the symptoms? _____

Current Medications: _____

Relevant Prior Medical History/Surgeries: _____

GOALS/Functional Levels: Your personal goals for therapy. Please choose all that are most important to you.

_____ Learn self-care techniques and prevention

_____ Resume/Improve self-care activities i.e. dressing, fixing hair, etc

_____ Resume/Improve household chores i.e. vacuuming, cleaning, meal prep, etc.

_____ Resume/Improve yard work, gardening, etc.

_____ Return to work activities

_____ Return to sports/recreation/hobbies

_____ Regain mobility/Increase flexibility

_____ Regain strength/Increase strength

_____ Increase sitting tolerance **Currently (Circle one):** Unable <5min <15-30min <1-2 hours

_____ Increase walking distance and speed **Currently (Circle one):** Unable <15ft <1 city block <1 mile

_____ Improve posture

_____ Improve/Return to driving

_____ Improve mobility on stairs/slopes

_____ Improve sleep **Currently (Circle one):** Wakes approx 1-2x/night approx 5-6x/night approx 10-12x/night

_____ Learn proper body mechanics; how to do what you do correctly

_____ Other

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL
INFORMATION\CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Stretch Physical Therapy in the event that they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. 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. This includes, but is not limited to, collection of service fees, attorney's fees and all other court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1% each month (12% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Stretch 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 excepting acts of negligence.

AUTHORIZED SIGNATURE_____

DATE_____

STRETCH POLICIES

Insurance Information: We will bill your medical insurance company. On your first visit to our office, please provide your insurance card and any additional information we may need for your treatment. It is recommended that you call your insurance company to verify your physical therapy coverage. It is your responsibility to know your policy benefits and limitations. Our office manager is available to answer questions you may have regarding our billing procedure.

Motor Vehicle Insurance: We will bill your open MVA claim. It is recommended that you call your insurance company to verify the amount of coverage and how much is available on your claim. In the event that coverage for services on your plan is for "reasonable and customary", you will be responsible for the amount not paid by your insurance. We will not bill a third party claim. If you do not have PIP coverage through your auto insurance, we can bill your private health insurance when supplied with a letter from your auto insurance stating that you do not have PIP coverage.

Workers Compensation Claims: We will bill your open, approved worker's compensation claim. Please be advised that in the event that your claim is denied, you will be financially responsible for all charges.

Payment Options: We accept personal checks, cash and major credit cards. Insurance co-payments are due on each visit. For all payments made in the clinic, a written receipt will be given to you. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. A 25.00 fee will be charged to the patient for each incident that a check is returned to us with insufficient funds.

Supplies: We will bill your insurance for any durable medical equipment that is covered by your insurance plan. Any non-covered supply costs are due at the time of service.

Scheduling: Consistent and timely attendance to your prescribed appointments is crucial in ensuring the best possible outcome from treatment to your condition. We realize emergencies may occur, resulting in the reschedule on an appointment. In order to best serve all of our patients, we ask that you notify us 24 hours in advance of a cancellation. Please be aware that failure to attend an appointment without proper notice may result in a \$75.00 cancel/no show fee charged to you. Repeated disregard for the attendance policy may result in discharge from treatment.

Patient Signature: _____ Date: _____

Stretch Physical Therapy
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Stretch Physical Therapy's Notice of Information Practices. I understand that Stretch Physical Therapy may use or disclose my personal health information for the purpose 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 clinic in writing. I also understand that Stretch Physical Therapy will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Stretch Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the clinic in writing at any time.

Patient Name _____

Signature _____

Date _____

Stretch Physical Therapy
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.

Stretch Physical Therapy's legal duty

Stretch 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

Stretch 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, Stretch 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.

Stretch 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 will provide information when required by law.

In any other situation, Stretch 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.

Stretch 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 any other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Stretch Physical Therapy will consider all such requests on a case-by-case basis, but is not legally required to accept them.

For questions or concerns you may contact the US Dept of Health and Human Services

200 Independence Ave SW
Room 509F, HHH Building
Washington, DC 20201

For the hearing impaired, contact the toll free TDD line at (800) 537-7697