History of Present Condition

Name:_____

Date of Birth: _____ Sex: F / M / _____ Pronouns: _____

Height: _____ Weight: _____ Occupation:_____

a. Why are you seeking care from a Physical Therapist?

b. Date of Injury / Surgery / Symptom Onset:	If surgery, what did you have done?

c. Have you received Physical Therapy for this problem before?	Y / N
d. In the last 30 days, have you received services from a hospital/nursing home/home health agency?	Y / N

e. What daily activities are you having difficulty with or what are your goals for physical therapy? (Be specific)

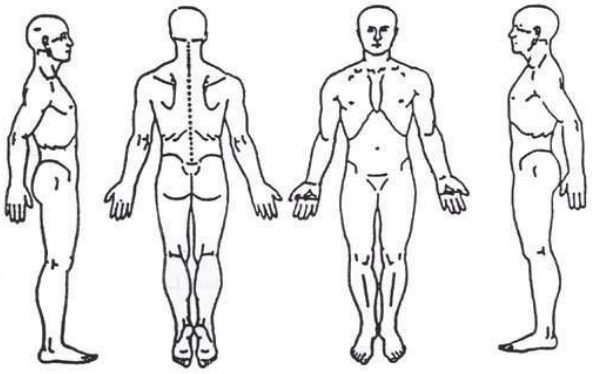
e. Have you had any imaging for this problem? If yes, complete below:

Diagnostic Image	Date Received	Results
X-Ray		
MRI		
CT Scan		
Diagnostic Ultrasound		

f. Please rate your pain on the scale below (Zero = No Pain, 10 = Severe Pain):

Pain at **BEST**	0 1 2 3 4 5 6 7 8 9 10
Pain at **WORST**	0 1 2 3 4 5 6 7 8 9 10

g. Please circle the location of your pain on the chart below:



Circle the word(s) that describe the quality of your pain:

Aching

Numbness

Pins & Needles

Burning

Stabbing

Dull

Other:_____

h. Have you fallen in the last 12 months? If yes, please explain last fall:

Patient Name _____

Medical History

a. Please list all medications you are currently taking OR provide a printed list of all medications (Required):

Medication Name	Frequency	Dosage	Route of Administration

b. Please mark all that apply to you currently or in the past:

	High blood pressure		Hernia		HIV
	Sensitive to ice/heat		Seizures		Vision problems
	Heart attack		Balance Issues/Dizzy spells		Diabetes
	Heart disease		Smoker		Headaches
	Kidney problems		Metal implants		Hearing problems
	Nervous disorder		Pacemaker		Arthritis
	Asthma		Ulcers/ stomach problems		Cancer

c. Please list any allergies you have:

d. Additional surgical history (heart, joint replacement, etc.):

Surgery:		Date:	
Surgery:		Date:	
Surgery:		Date:	
Surgery:		Date:	

e. Is there anything else you would like your Physical Therapist to be aware of?

The above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____Date: _____

Physical Therapist Signature: _____ Date: _____

Physical Therapist Printed Name:_____

Patient Name _____

Cancellation & No-Show Policy

We are sincerely dedicated to assisting you in meeting your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program, which will result in quicker recovery and better outcomes.

If it is necessary to cancel or reschedule your appointment, **we require that you notify our front office staff at least 24 hours in advance and receive confirmation that the appointment has been cancelled.** Appointments are in high demand, which is why Seattle Rehab Specialists follows a strict cancellation policy, and your early cancellation will allow the appointment to be reallocated to another patient who will benefit from the treatment.

When a patient is late the entire schedule is affected. Therefore, we politely ask that our patients be prompt in being present at the time of their scheduled appointments. **We reserve the right to reappoint patients arriving 15 minutes after their scheduled appointment time and assign a late fee.**

Late Cancellations: Cancellations are considered late when an appointment is cancelled with less than 24 hours' notice.

- A **1st Time Cancellation Fee of $100.00** will be charged to the patient for the first late cancellation.
- A **Cancellation Fee of $150.00** will be charged to the patient for every additional late cancellation.
- **Illness:** If you are not feeling well or are concerned about Covid exposure and will not be able to make your appointment, you will need to inform the front office **before 10 AM** the day of your appointment to avoid a cancellation fee.
- Cancellation fees will be waived if the patient is able to reschedule within the same week. If the appointment is on a Friday, there is no option to reschedule and have the fee waived.

No Show Policy: A "no-show" is a patient who misses or doesn't show for an appointment without cancelling it.

- A **No Show Fee of $150.00** will be charged to the patient.

Payment

- For patients who have a Credit Card on file, fees will be collected the following business day.
- HSA/FSA cards cannot be used to pay cancellation fees.
- Patients with no card on file or an HSA/FSA card on file, fees will be collected at your next appointment.
- These fees are not covered by your insurance.

Day-of-Status

In the circumstance a patient has no-showed two appointments or late cancelled three appointments, Seattle Rehab Specialists reserves the right to move patient to "Day Of" status. The patient will no longer be permitted to book appointments in advance but can call the clinic on a day when they know they have availability to see if we have openings on the schedule that day.

Helpful Hints to Avoid Fees:

- Ask the front office to activate either an email or text appointment reminder notification.
- Check out with the front desk after every visit to confirm your next appointment.
- Request a printout of all your scheduled visits from the front desk and retain this for your reference.
- If you need to cancel, call Seattle Rehab Specialists and speak to a front office representative or leave a message if after hours.
- The front office is responsible for all therapists' schedules, so always inform the front office of cancellations or needs to re-schedule. ****Telling/calling a therapist and/or aide is not sufficient notice.**

Patient Responsibilities

1. **Check-in & Sign-in for each visit:** Please check in with the front office at every visit. You will need to sign in on the sign-in sheet at each visit.

2. **Payment is due at the time of service:** Deductibles, co-insurances, co-payments self-pay, & wellness payments are due at the time of your appointment. For your convenience, Seattle Rehab Specialists urges you to place a credit card on file for automatic payments at the time of your appointment.

3. **Update your information with the front office:** Please inform the front office of any changes to your insurance and/or personal information. This is imperative to ensure all claims are processed correctly and in a timely manner.

4. **Scheduling appointments:** Appointment availability is on a first-come, first-served basis. To secure your preferred times, we recommend scheduling future appointments as far in advance as possible.
   **Please note that the front office does not schedule any appointments without the patient or guardian requesting that date and time; regularly reoccurring days or times are not guaranteed beyond the dates explicitly scheduled.*

5. **Personal belongings:** There are small cubbies your personal effects. The cubbies do not lock and you assume the liability for the safety of your personal items.

6. **Check-out with the front office after each visit:** Please check out with the front office after every visit. The front office will confirm your next appointment and assist in scheduling future appointments at this time.

Patient Information Consent: HIPAA Release

I have read and fully understand Seattle Rehab Specialists' Notice of Information Practices. I understand that Seattle Rehab Specialists 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 practice. I also understand that Seattle Rehab Specialists 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 use and disclosure of my personal health information for purposes as noted in Seattle Rehab Specialists' Notice of Information practices. After treatment is completed, I understand that I retain the right to revoke this consent by notifying the practice in writing.

By signing below, I acknowledge and agree to all three above policies & procedures (Cancellation/No Show, Patient Responsibilities & HIPAA Release)

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

Photo and Video Release (Optional)

I hereby authorize Seattle Rehab Specialists to use my testimonial, photos, videos, audio and any information contained herein in its media, public relations, marketing, social media, and educational efforts. I understand and approve the disclosure of the testimonial, photo, video, or audio information to the media and other individuals and entities that may be involved in these efforts for Seattle Rehab Specialists.

I authorize Seattle Rehab Specialists to disclose limited information about my condition or treatment for these purposes, and understand that no other protected information will be disclosed publicly, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Seattle Rehab from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio or information in the testimonial. By signing below, I agree and acknowledge that I have read and understood the above release and agree to all terms described.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

Patient Name _____

Credit Card Authorization (Optional)

Payment for services (deductible/copay/coinsurance, self-pay/wellness) are due IN FULL at the time of service. At the beginning of treatment, we request you secure your account with a credit card. This card will only be charged with your permission (indicated by your selection below). We offer two options for charging the patient responsibility relating to your treatment. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the quoted benefits from your insurance company throughout your treatment. Once your claims have been processed, the Explanation of Benefits from your insurance company will determine the patient responsibility and any necessary changes to the amount due will be made. Additionally, we will use the credit card to process any cancellation or no-show fees that you have incurred (FSA/HSA Cards will not be charged cancellation and/or no-show fees). A receipt will be provided for any charges processed by Seattle Rehab Specialists, at your request. If you prefer to bring in payment at every appointment, we will use your credit card to charge any remaining fees or balances owed once claims have processed by your insurance company and/or any missed payments for services already provided.

Credit Card Information			
☐ Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ FSA ☐ HSA			
Name on Card:			
Card Number:			
Expiration Date:		Security Code:	
Billing Address:			
Do You Require an Itemized Receipt?	☐ Yes ☐ No (will be provided at end of treatment)		

Please Initial the Option You Prefer	
Initial	**CHARGE AT TIME OF SERVICE:** I agree to allow Seattle Rehab Specialists to automatically charge my credit card on file for the amount due when I check-in for each appointment, as well as for any fees or remaining balanced owed.
Initial	**BALANCE OWED ONLY:** I will present a card at each visit to pay the estimated amount due per session and will have my credit card on file available **only** for any remaining balance I owe for fees or services.

☐ I require notification for any charge larger than $_____ ☐ I don't require notification.

I have read this Financial Policy, and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Seattle Rehab Specialists, Inc. Furthermore, authorize my health insurance company to send payments for covered services directly to Seattle Rehab Specialists, Inc and understand that I am responsible for any costs not covered by my health insurance.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____