Timberline Physical Therapy
REGISTRATION FORM

(Please Print)

Today's date:	**Email Address for our Newsletter:**		

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	**Pronouns:** ❑ He/Him ❑ She/Her ❑ They/Them ❑ No Pronoun ❑ Prefer not to say

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**		**Birth date:** / /	**Age:**
Street address / P.O. Box		**Social Security no.:**	**Home phone :** ( )	
City/State/Zip:			**Cell Phone:** ( )	
Occupation:	**Employer:**		**Employer phone no.:** ( )	

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Hospital	❑ Insurance Plan	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑Internet
❑ Motor Vehicle Accident	❑ Workmen's Comp	❑ No Insurance		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Company:	**Address:**	**Insurance Phone:** ( )
Policy Number:	**Group Number:**	
Employer:		**Employer phone no.:** ( )

Are you covered by more than one insurance company?	❑ Yes	❑ No		
Please indicate primary insurance	❑ MVA	❑ Work Comp	❑ Medicare	❑ Cash

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Guardian Name (please Print):

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Phone no.:** ( )	**2nd Phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Timberline Physical Therapy or insurance company to release any information required to process my claims. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 12% per year of the unpaid balance, UNLESS financial arrangements have been made prior. A $50 bank fee will be charged for NSF checks.

If the patient is a minor, a parent or guardian must sign below to consent to treatment and agree to financial responsibility for the care.

_____ _____

Patient Signature (Guardian if patient under 18 yrs or mentally disabled child/adult) ***Date***

TIMBERLINE
PHYSICAL THERAPY

MEDICAL RELEASE OF INFORMATION

I, _____, authorize the office of Timberline Physical Therapy to release information concerning my insurance information, medical history, diagnosis, treatment, prognosis and recommendations, as well as other pertinent data regarding my insurance, healthcare or upcoming appointments to:

(Check all that apply)

☐ Spouse (name) _____

☐ Any other Family member (names) _____

_____

☐ Home phone answering machine/service ☐ Cell phone answering machine/service

☐ Work phone ☐ Other (specify ie: email)_____

TREATMENT QUESTIONS

Is this injury due to a motor vehicle accident or personal injury? ☐Yes ☐No

If YES, is there an open claim? _____

Is this injury due to a work-related injury? ☐ Yes ☐No

If YES, is there an open claim? _____

Have you been treated for Physical/Occupational/Speech therapy this year?

If YES, how many visits this year?_____

Are you currently getting treatment from another therapy office? ☐Yes ☐ No

_____

Signature of Patient Date

TIMBERLINE
PHYSICAL THERAPY

Date: _____ Name: _____

Occupation: _____ Height: _____ Weight: _____

Referring Physician/Clinic: _____

Date of Injury: _____ Date of Surgery: _____ Diagnosis: _____

What major complaint/symptom/issue brings you here today?

_____

How did it start?

_____

How long has it been happening?

_____

Are your symptoms getting: ☐ Better ☐ Worse ☐ Staying the same

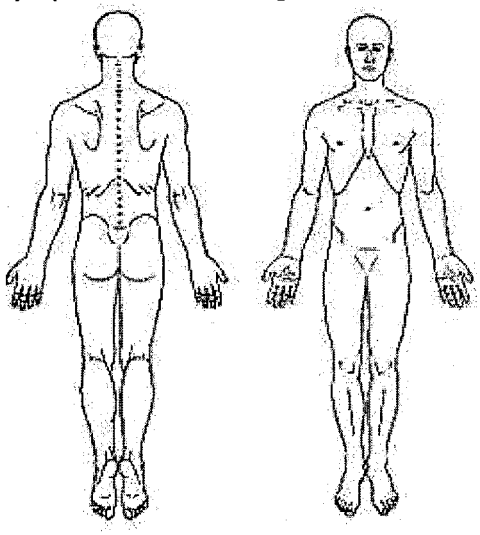
Are your symptoms: ☐ Constant ☐ Intermittent

Place three circles below to indicate the intensity of your pain on **average**, at **best**, and at **worst.**

0 1 2 3 4 5 6 7 8 9 10

No Pain..... ....Worst Pain Imaginable

Please indicate the location of your symptoms on this diagram:



Please check the box of the activity that increases your pain or symptoms:

☐Walking	☐Household/Yard work	☐Sleeping/resting	☐Other:_____
☐Standing	☐Sports	☐Playing with kids	_____
☐Sitting	☐Bathing/dressing	☐Climbing stairs	
☐Sit to Stand	☐Driving/riding in a car	☐Computer work	
☐Reaching	☐Exercise	☐Lifting/carrying	

What decreases your pain/symptoms?:_____

_____

What are your goals for Physical Therapy:

_____

Have you seen any of the following during the past 3 months?

☐Physician ☐Chiropractor ☐Acupuncturist ☐Massage Therapist ☐Physical Therapist

Past Medical History – Please check the box if you have or have ever had any of the following:

☐Anxiety	☐High Blood Pressure	☐Stroke	☐Fractures
☐Depression	☐Pacemaker	☐Thyroid problems	☐Sprains/strains
☐Diabetes	☐Heart problems	☐Osteoarthritis	☐Fibromyalgia
☐Lung problems	☐Dizziness/Vertigo	☐Rheumatoid arthritis	
☐Liver problems	☐Recent falls	☐Headaches	☐Vison problems
☐Cancer	☐Heart attack	☐Motor Vehicle Injury	
☐Osteoporosis	☐Recent weight loss/gain	☐Balance problems	☐Hearing problems

Use the following lines to explain/describe any of the above checked conditions if needed:

_____

_____

Are you a (circle one) current smoker? Yes or no - if yes, how much do you smoke?_____

If no, when did you quit smoking? _____

Have you had any past surgeries or hospitalizations? ☐ Yes ☐No (please list them if yes)

_____

_____

Have you had any of the following tests performed for this problem?

☐X-Ray ☐MRI ☐CT Scan ☐Bone Scan ☐Blood Test ☐Other:_____

Results:_____

Allergies:

☐Medications ☐Latex ☐Adhesive Tapes ☐Other

List:_____

Medications: Please list all prescription and non-prescription medications (especially heart related):

_____

_____

TIMBERLINE
PHYSICAL THERAPY
920 NE 112th Avenue, Suite 103, Vancouver, WA 98684
360-567-2002 Ph. 360-567-2005 Fax

Financial Policy

Thank you for choosing Timberline Physical Therapy for your physical therapy needs. We will work closely with you and your physician to provide you with a successful plan of care. Please understand that timely payment for your treatment is an important role in the process. Your clear understanding of our financial policy is vital to our professional relationship.

Our policy states:

- All co-pays, co-insurances and deductibles are due at the time of service.
- Payment is due in full at time of services unless arrangements have been made.
- If you are unable to make full payment at the time of service please ask to speak with our Office Manager.
- We accept cash, checks or credit/debit cards
- If any portion of your account balance exceeds 60 days, you will be held responsible for this amount
- Accounts over 60 days are subject to a finance charge at an accrual rate of 1% per month.

Insurance

Timberline accepts Medicare, all major insurance companies and numerous PPO and managed care contracts. Please be aware that some and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be held responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Timberline Physical Therapy will submit all claims and charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, failure to present this prior to services rendered may result in a loss of benefits. If you need assistance in obtaining this referral please contact our front office. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to a collection agency and you will be held responsible for all fees incurred.

Please be advised there will be a $50 fee for NSF checks

Thank you for understanding our financial policies. If you have concerns please discuss them with our Office Manager or Billing Specialist.

Patient Signature **Date**

Parent/Guardian Signature (if patient under 18 years of age – signature required) Date

TIMBERLINE
PHYSICAL THERAPY
920 NE 112th Avenue, Suite 103, Vancouver, WA 98684
360-567-2002 Ph. 360-567-2005 Fax

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 CAREFULLY.

Timberline 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 DISCLOSURE OF HEALTH INFORMATION

Timberline Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. For example, we may use your personal 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.

Timberline may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any situation, Timberline'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 disclosures at any time.

We may change our 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, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Timberline Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

Patient Signature **Date**

Parent/Guardian Signature (if patient under 18 years of age – signature required) Date

TIMBERLINE
PHYSICAL THERAPY

920 NE 112th Avenue, Suite 103, Vancouver, WA 98684
Phone: 360-567-2002 Fax: 360-567-2005
www.TimberlinePT.com

CANCELLATION POLICY:

Due to the nature of our business having an updated schedule is of utmost importance, we appreciate your cooperation.

A $50.00 cancellation fee for any appointment not cancelled within 24 hours of the scheduled appointment.

If there are TWO consecutive missed appointments, we will remove all future appointments. Patient will then be required to call on the day that they will be available to see if we have any openings.

When you do not keep a scheduled appointment, three people are hurt:

YOU – because you are not getting the treatment you need.

The Therapist – who has an open space in the schedule which was reserved for you.

Another Patient – that could have been scheduled if you would have given our office proper notice.

I agree to above stated cancellation policy:

_____

Patient Signature Date

_____

Parent/Guardian Signature (if patient under 18 years of age – signature required) Date