



920 NE 112th Avenue, Suite 103, Vancouver, WA 98648

Phone: 360-567-2002 Fax: 360-567-2005

www.TimberlinePT.com

Thank you for selecting Timberline to be a part of your rehabilitation. Below we have condensed most of our policies as to be efficient with your valuable time. Please review:

-

Intake form: This is to aid in the initial evaluation process. It is a small glance into your medical health and this particular episode of pain.

Registration Form: This form allows for personal/contact information and insurance information to assist with verification of benefits.

Financial Agreement: This explains in detail the professional relationship between the patient and Timberline Physical Therapy.

HIPAA: This form will explain your rights as a patient and to your privacy.

1) Release of Records: I authorize Timberline Physical Therapy to request a copy of my medical records and/or billing statements for the purpose of assisting in my rehabilitation. I also authorize Timberline Physical Therapy to release or discuss all medical information with my healthcare providers, case managers, lawyers, or others involved in my care.

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

A \$35.00 cancellation fee for any appointment not cancelled within 24 hours of scheduled appointment. NO SHOW of appointment times will also be assessed with the same \$35.00 fee.

I agree to above stated release of records, cancellation policy, and certify that I have either printed above mentioned forms online or been given forms at clinic.

Patient Signature

Date

Timberline Physical Therapy REGISTRATION FORM

(Please Print)

Today's date:				Email:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address / P.O. Box			Social Security no.:		Home phone : ()		
Cell Phone:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Internet			
<input type="checkbox"/> Motor Vehicle Accident		<input type="checkbox"/> Workmen's Comp		<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> MVA	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Medicare	<input type="checkbox"/> Cash		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative:		Relationship to patient:	Phone no.: ()
			2 nd Phone no.: ()
<p>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.</p>			
<hr style="border: 0; border-top: 1px solid black;"/> <i>Patient/Guardian signature</i>			<hr style="border: 0; border-top: 1px solid black;"/> <i>Date</i>



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Date: _____ Age: _____
Name: _____ Work Status (circle): Normal/Light Duty/
Occupation: _____ Reduced Hours/Off
Height: _____ Weight: _____ Handedness (circle): Right Left
Referring Physician: _____ Diagnosis: _____
Date of Injury: _____ Date of Surgery: _____

What major complaint, symptom, or problem brings you here today?

Describe your symptoms specifically:

How did your symptoms begin, and how have they progressed?

Have you had this problem before?

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

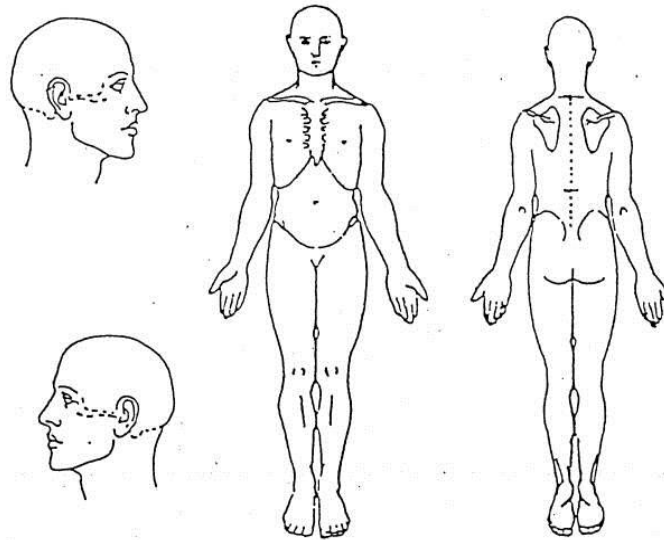
Do you have trouble falling asleep due to your symptoms? Yes No

Is your sleep restful? Yes No

How many times do you awaken during the night? _____

How long does it take you to go back to sleep? _____

Please indicate the location of your symptoms:



What increases your pain/symptoms? _____

What decreases your pain/symptoms? _____

What specific activities are you unable to do because of your symptoms? _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Household chores | <input type="checkbox"/> Sleeping/resting |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Yard work | <input type="checkbox"/> Playing with kids |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bathing/dressing | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Sit to stand | <input type="checkbox"/> Driving/riding in car | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lifting/carrying | <input type="checkbox"/> Sports | |

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

- | | |
|---|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Other: |

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

- X-ray MRI CT scan Bone scan Blood Tests Other

Results: _____

Past Medical History

Do you have or have ever had any of the following?: (circle)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Recent falls | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Motor vehicle injury | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Neck/back problem | <input type="checkbox"/> |

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

Have you had any past surgeries or hospitalizations? Yes No (List)

Medications:

Please list all prescription and non-prescription medications:

Allergies:

- Medications Latex Adhesive tapes Other

List: _____

What are your goals for physical therapy?



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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 of 15%

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



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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