ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

PATIENT REGISTRATION

PATIENT

First Name:_____ ___ MI _____ Last Name _____ DOB: ___/___/____

Address _____City_____State___ Zip_____

Primary Phone ( ) _____ Secondary Phone ( ) _____ Gender ☐ Male ☐ Female

Email _____ Appointment Reminders ☐ Phone ☐ Text
(for clinic use only, not for marketing or third party use)

EMERGENCY CONTACT

Name _____Relationship _____Phone ( )_____

PRIMARY INSURANCE INFO

Insurance _____

ID #_____

Group #_____

Subscriber Name _____

Subscriber DOB _____

SECONDARY INSURANCE INFO

Insurance _____

ID #_____

Group #_____

Subscriber Name _____

Subscriber DOB _____

☐ SELF PAY

I choose to pay for therapy services out of pocket. **20% Discount for full payment at the time of service.**

Please present your Insurance Card(s) to the front desk staff.

CLAIM INFORMATION (for Work or Auto Injuries Only)

☐ W-Comp (L&I) Claim ☐ MVA/PIP Claim # _____ Date of Injury ___/___/____

Claim Manager's Name _____ Phone ( ) _____-_____

Company Name: (PIP or employer) _____

HOW DID YOU HEAR ABOUT US?

Doctor Family Friend Internet Phone Book Former Patient Other:_____

ACKNOWLEDGEMENT

Patient's or authorized person's signature:

- I authorize the release of any medical records or other information necessary to process claims.
- I authorize payment of medical benefits to Associates in Physical Therapy, PLLC.
- I am financially responsible for any balance due on all covered or non-covered services.

Signature_____ Date: _____
(Parent/Guardian if patient is a minor)

ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

FINANCIAL POLICY

Standard Insurance Policy:

- Coverage depends upon your insurance company and the specific plan you have chosen.
- You may need a current prescription, referral, or authorization for physical therapy services based on your insurance plan.
- Co-pays are due at the time of service.
- Benefit details are not a guarantee of payment.

Pre-Authorization Policy:

- If your plan requires pre-authorizations, AIPT will complete and submit all required documents.
- Authorizations are based on the insurance company's medical necessity review and criteria, not on plan benefit limits.
- If your authorization is "pending" you may still choose to have physical therapy to avoid a delay in care, however you will be accepting the financial responsibility should the authorization be denied.

Medicare Policy:

- You are required to have a prescription for physical therapy.
- You must be discharged from any home health care services or agency prior to initiating outpatient physical Therapy. Medicare will not pay for both home health and outpatient care simultaneously.
- Medicare has a SHARED dollar limit on Physical Therapy and Speech Therapy for each insured per calendar year. In order for us to track your allowed amount, we must have an approximate amount used at any other facility for speech or physical therapy. If we do not have these amounts we can only track what has been used at our facility. This may result in additional out of pocket expenses to you.

Auto PIP/Third Party:

- We will bill your PIP if you have a claim open and you have medical coverage with your auto insurance policy.
- If you do not have a direct PIP Claim you can choose to have us submit to your personal insurance or pay at the time of service at the Self-Pay rate described below. Payment at settlement with a third party is on a case by case basis. You may be required to make payments until settlement.

Self-Pay Policy:

- For patients without insurance coverage, or for those patients that have exceeded insurance benefits, a 20% discount is available for full payment **at the time of service**.

Paying Your Bill:

- You will receive a monthly statement in the mail for any non-covered or unpaid balances on your account.
- All unpaid balances that exceed 120 days will be assigned to a third party collection agency.
- Payment plans due to financial hardship will be considered upon special request.
- A fee of $25.00 will be charged for any check returned by the bank for Non-Sufficient Funds.

I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.

Signature_____ **Date:**_____

ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

CANCELLATION POLICY

Patients are seen, at AIPT, by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments a few weeks in advance.

In the event you need to cancel an appointment, we require at least **24 hours notice.** Your appointment time is very important to us. When you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to seemingly "full" appointment book.

If we do not get at least 24 hours notice of your cancellation, or you do not arrive for your scheduled appointment (no-show), you may be assessed a $35.00 fee. This fee will not be covered by your insurance company.

We realize that emergencies do occur – late cancellation due to illness or family emergency is EXCLUDED from this policy.

I have read and understood the above policy.

Signature:_____ Date: _____

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of Associates in Physical Therapy's(AIPT) *Notice of Privacy Practices* containing a more complete dexcription of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of *Notice of Privacy Practices.* I understand that AIPT has the right to change the *Notice of Privacy Practices* and that I may contact this office at 230 Grant Rd. Ste. B27, East Wenatchee, WA 98802 or at www.myAIPT.com to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that AIPT is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature_____ Date:_____

I give permission for the following individual(s) to request treatment or account information:

_____

_____

Initials:_____

ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

Name:_____ DOB:_____ Today's Date_____

Initial Evaluation Form

1. Main Complaint (Reason for your visit today): _____

2. When did it start?:_____Is it: __Improving __Getting Worse __Staying same

3. How did it begin?:

___Motor Vehicle Accident ___Work Related Injury ___ Sports/Exercise Injury

___Post-surgery ___ Unknown Cause ___ Chronic Condition/Illness

___ Other (Briefly explain):_____

4. What **increases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Lifting __Bending __Squatting

__Reaching overhead __Coughing/Sneezing __Stress/Anxiety __Running/Jumping

__Other:_____

5. What **decreases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Massage __Heat __Ice __Medication

__Other:_____

6. Is your sleep disturbed due to pain? Yes or No

(if yes please explain)_____

7. Have you had any recent tests or imaging (past 3 months)?

__ X-ray __MRI __CT Scan __EMG __Bone Scan __Blood Tests __Ultrasound

__Other:_____

8. Have you had any treatment for this problem? (if yes please list):

_____

9. Do you have a pacemaker or any metal implants? Yes or No

10. Please list any surgeries (Including approx date):_____

_____

11. Please list any **prescription medications** :_____

12. Have you been diagnosed with any of the following conditions (circle all that apply)?:

Arthritis	Balance Problems	Bowel/Bladder Problems	Heart Condition
Lung Condition	Cancer	Depression/Anxiety	Diabetes
Dizziness/Fainting	Eiplepsy/Seizures	High Blood Pressure	HIV/AIDS
Stroke	Vision Problems	Jaw Problems (TMJ)	Pregnancy (current)
Osteoporosis	Infection (current)	Other:_____	

13. Use of Tobacco: __ Never/Infrequent __Previously but quit __Current pack/day:___

14. Use of Alcohol: __ Never __Rarely __ Moderate (2-4 drinks per week) __Daily

15. Use of Caffeine: __Coffee __Tea __Sodas (Drinks per day:_____)

ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

16. Exercise: __Never __Rarely __Weekly __Daily (Type of exercise:_____)

17. Employment: ___Working normal duty ___Currently light duty ___Not currently working ___Retired

Job Title:_____ Physical Demands: __Sedentary/Computer __Light __Medium__Heavy

18. Which activities are difficult for you because of your pain complaint (circle all that apply)?:

Sitting Standing Walking Reaching Lifting Pushing Pulling Carrying Sleeping Other_____

Work Limitations/Restrictions:_____

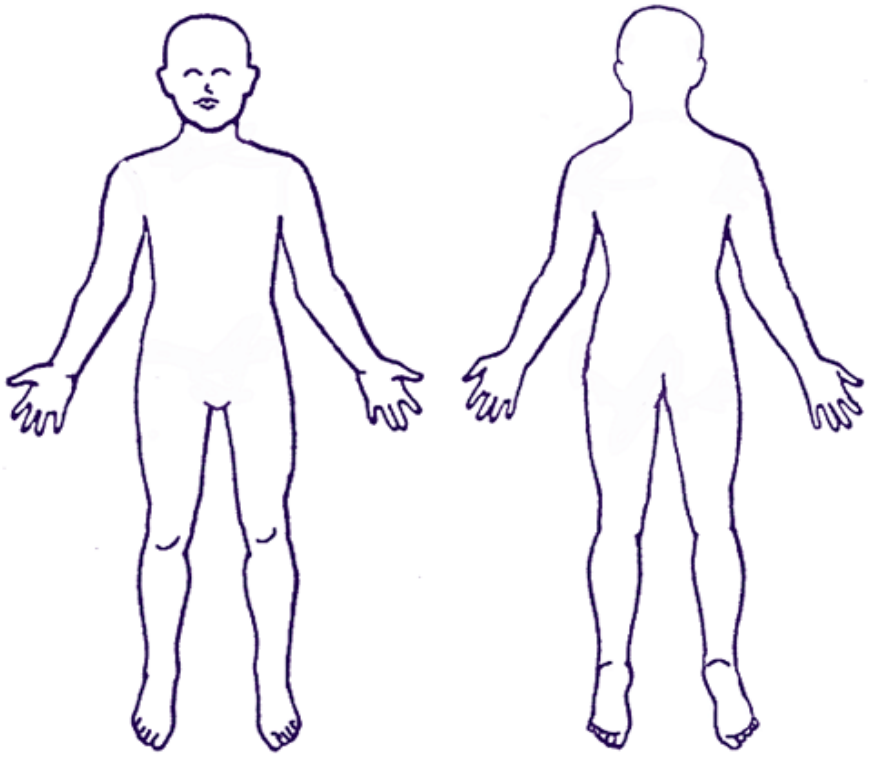
19. Pain Assessment:

Circle the number that represents your level of pain at **best and at **worst** in the last few days:

Pain at **Worst**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)
Pain at **Best**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)

Objective Findings: *(This section filled in by staff)*

Vital Signs:	Height:	BP:
(Filled in by staff)	Weight:	HR:



_____ _____

Patient Signature *(or legal guardian/caregiver)* Date Therapist Signature Date