South Sound Physical & Hand Therapy
An Affiliate of IRG Physical & Hand Therapy

PATIENT INTAKE FORM

PATIENT INFORMATION

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

Preferred Name _____ Preferred Pronoun _____

Address _____ Apt#_____ City _____ State _____ Zip _____

Cell Phone (_____) _____-_____ Alternate Phone (_____) _____-_____ ❑ Male ❑ Female

May we leave a detailed voicemail/text message if we are unable to reach you in person? ❑ Yes ❑ No

Email Address _____ *(IRG will not share, sell or trade your information)*

I would like to receive appointment reminders via ❑ Email ❑ Text Message Cell Phone Carrier: _____

Referring Provider _____ PCP _____ Last MD Visit ___/___/_____

How did you hear about our office? *(select all that apply)* ❑ Doctor ❑ Friend/Family ❑ Website/Social Media ❑ ATC/Coach ❑ Community Event/Presentation ❑ Radio/TV ❑ Flyer/Postcard Other: _____

If patient is under 18, name of parent/guardian completing and signing intake paperwork:
Name: _____ Relationship _____ Phone (_____) _____-_____

In case of an emergency, please contact:
Name: _____ Relationship _____ Phone (_____) _____-_____

MEDICAL INSURANCE INFORMATION

Estimate of benefits will be given at check-in.

Primary Insurance: _____ Secondary Insurance: _____

Did your injury or condition occur at work or as a result of a motor vehicle accident? ❑ Yes ❑ No
If Yes: ❑ L&I/Workers Comp ❑ Motor Vehicle Accident Date of Injury ____/____/_____

HIPAA PRIVACY NOTICE

Please check one:

CLICK TO VIEW HIPAA NOTICE

❑ I acknowledge receipt of a copy of the Notice of Privacy Practices
❑ I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information with:

Name: _____ Relationship _____
Name: _____ Relationship _____

CONSENT TO TREATMENT / ASSIGNMENT OF BENEFITS

By signing below:

- I hereby consent to evaluation and treatment (or the evaluation and treatment of my dependent) at Integrated Rehabilitation Group (IRG) & Affiliates.
- I authorize all available medical insurance benefits be directly assigned to Integrated Rehabilitation Group (IRG) & Affiliates for services rendered.
- I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature _____ Date _____
(Parent or Guardian signature if patient is a minor)

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MEDICAL QUESTIONNAIRE

GENERAL INFORMATION

Name _____ DOB ___/___/_____ Age _____

Date of Injury or Onset of Symptoms: ___/___/_____ Date of Surgery (if applicable): ___/___/_____

Employer: _____ Occupation: _____

Where did your injury occur? ❑ Work ❑ Auto/MVA ❑ Home ❑ Other: _____

Side of Injury: ❑ Right ❑ Left ❑ Bilateral

Briefly describe how your injury occurred: _____

Briefly describe your present symptoms: _____

Does your pain level change over the course of day and night?: _____

Have you had any of the following treatment and/or tests for this condition? *(check all that apply)*

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Home Health ❑ Acupuncture

❑ Hospitalization ❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Injections ❑ Other: _____

Please list the names of practitioners you have seen for this condition:_____

_____

What do you hope to accomplish with therapy? *(your personal goals):* _____

_____

MEDICAL HISTORY *(check all that apply)*

❑ Allergies: _____
❑ Anxiety
❑ Asthma
❑ Arthritis
❑ Blood Clots
❑ Bruise Easily
❑ Cancer: _____
❑ **Other:** _____

❑ Depression
❑ Diabetes
❑ Dizziness/Vertigo
❑ Fibromyalgia
❑ Fractures

❑ Heart Disease
❑ Hepatitis
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV/AIDS
❑ Hypoglycemia
❑ Kidney Problems

❑ MRSA
❑ Multiple Sclerosis
❑ Osteoporosis
❑ Seizures
❑ Sensitivity to heat or ice
❑ Stroke
❑ Traumatic Injury

❑ **No Significant Medical History**

OTHER MEDICAL INFORMATION

Height: _____ Weight:_____ Do you have a pacemaker? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Do you smoke tobacco? ❑ Yes ❑ No If yes, how much_____ how long _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much_____

How would you rate your overall health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you exercise outside of normal daily activities? ❑ Yes ❑ No

List any surgeries/major accidents/illnesses with dates: _____

_____

List all current medications *(or provide front desk with a list that can be copied into your medical record)*: _____

_____

Signature _____ Date _____

(Parent or Guardian signature if patient is a minor)

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FINANCIAL POLICY

GENERAL FINANCIAL & CANCELLATION POLICY

As a courtesy, you will receive an estimate of benefits at check in. This is an estimate only and not a guarantee of payment. Our Billing Department is available to discuss any questions you may have regarding your insurance or account at 425-357-9380 or 1-877-228-9217 during the hours of 7:00 AM to 5:30 PM Monday through Friday.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for payment of services provided.

DOCTOR REFERRALS: You are responsible for obtaining the appropriate referral from your physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral in the office at the time of your appointment. Exceptions to this policy would be those plans that have direct access to therapy with no referral required.

PAYMENT ISSUES: If financial problems arise, please contact our Billing Department as soon as possible. Payment plans are available. However, if you or the person financially responsible does not adhere to the payment plan, the balance will become due immediately. If an account becomes past due, necessary action will be taken, up to and including turning the account over to our attorney or collections service.

CANCELLATION POLICY: If you need to cancel an appointment we require 24 hour notice as a courtesy to other patients and your therapist. Failure to give 24 hours notice will result in a $50 fee not payable by your insurance company. Arriving to your appointment more than 10 minutes after your scheduled time may be subject to the $50 fee. Patients with multiple no-shows or late cancellations could have all remaining appointments removed

FINANCIAL POLICY - MVA

We are unable to carry large balances for patients with little or no guarantee of payment. Our Billing Department is available to discuss any questions you may have regarding your insurance or account at 425-357-9380 or 1-877-228-9217 during the hours of 7:30 AM to 5:30 PM Monday through Friday.

PIP COVERAGE: We are required to bill your Personal Injury Protection (PIP) carrier for services rendered regardless of whom was at fault of the accident. If your PIP coverage is exhausted or refuses to pay we will bill your private health insurance company.

MEDICAL LIEN FILED WITH THE OTHER DRIVERS INSURANCE (3rd Party): If your PIP or private insurance fail to provide payment to Integrated Rehabilitation Group, Inc & Affiliates, we will file a medical lien with the other drivers insurance company for patient balance amounts exceeding $1500. We will defer the monthly payments on balances exceeding $1500. If a lien is filed we will allow you to carry a maximum balance of $4000. A lien fee in the amount of $150 will be charged to your account annually from the date of the lien filing.

ATTORNEY: If you retain an attorney, you are required to provide us with your attorney's information and agree to the following:
* The patient will authorize and direct their attorney to pay directly to Integrated Rehabilitation Group, Inc. & Affiliates such sums as may be due and owing to them for services rendered to the patient as a result of the accident, and to withhold such sums as may be necessary to pay Integrated Rehabilitation Group, Inc. & Affiliates.
* The patient agrees to notify Integrated Rehabilitation Group, Inc. & Affiliates if their attorney is changed or discharged. The patient also agrees to promptly notify Integrated Rehabilitation Group, Inc. & Affiliates if a settlement, award, or a verdict is reached and there is a balance due.
* The patient acknowledges that Integrated Rehabilitation Group, Inc. & Affiliates is not responsible and shall not pay any attorney's fees, expenses or costs in connection with the patient's claim or action.

PRIVATE PAY: If you want to private pay (month by month) on your account, you will be sent a monthly statement to your home address for the full amount of charges for each date of service**.** *A minimum monthly payment of 50% of the billed charges on your statement will be due every 30 days*.

SIGNATURE

I understand that I am financially responsible for all charges for services rendered by Integrated Rehabilitation Group, Inc. & Affiliates. I understand that any benefits estimated are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the Financial and Cancellation policy and by signing below I understand and agree to the terms therein.

Signature _____ Date _____
(Parent or Guardian signature if patient is a minor)