TIMBERLINE
PHYSICAL THERAPY
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:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /	Age:	Sex: ❑ M ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ 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

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.

Patient/Guardian signature *Date*

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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 you 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

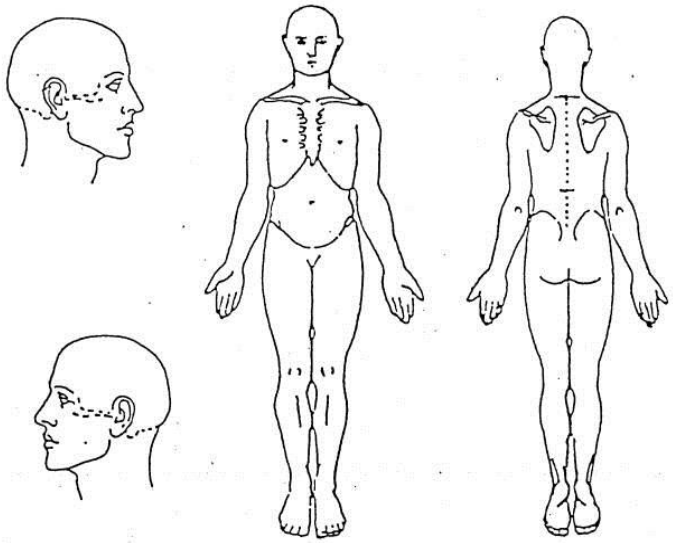
Do you have trouble falling asleep due to your symptoms? □ Yes □ No

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:

- □ Walking
- □ Standing
- □ Sitting
- □ Sit to stand
- □ Reaching
- □ Lifting/carrying
- □ Household chores
- □ Yard work
- □ Bathing/dressing
- □ Driving/riding in car
- □ Exercise
- □ Sports
- □ Sleeping/resting
- □ Playing with kids
- □ Climbing stairs
- □ Computer work
- □ Other:

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

- □ Physician
- □ Physical Therapist
- □ Massage Therapist
- □ Chiropractor
- □ Acupuncturist
- □ 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)

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

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**