Office Use Only:
Height: Weight:

Patient Registration

Date: ____________

Patient Name: ______________________ Date of Birth: ______________

Patient Employer: ______________________ SSN: ______________

Occupation: ______________________ Phone: ______________

Spouse/Guardian Name ______________________ Phone: ______________

Spouse/Guardian Employer: ______________________ Phone: ______________

Marital Status: ☐ Single ☐ Married ☐ Other: ________ Emergency Contact: ______________ Phone: ____________

Which of the following may we leave a message with? (circle all that apply):

Home VM	Cell VM	Spouse	Family	Work	Attorney	Claims Manager	Claims Adjuster

Have you been or are you currently being treated by a Massage/Speech/Occupational Therapist or Chiropractor this year?

☐ NO ☐ YES Name: ______________________ Contact number: ______________

Work and Automotive Injury Information

Is your injury the result of an accident at work? ☐ NO ☐ YES **Date of Injury:** ______________

Which carrier did you file with? WA State L&I ☐ Employer Self-Funded ☐ Your Claim Number: ______________

If you selected Employer Self-Funded who is the carrier: ______________________

Claims Manager Name: ______________________ Phone Number: ______________

Is your injury the result of an automobile accident? ☐ NO ☐ YES **Date of Injury:** ______________

Name of <u>YOUR</u> Auto Insurance Carrier – Personal Injury Protection (PIP): ______________

Policy/Claim Number: ______________________ Date of Accident: ______________

Agent/Claim Adjuster: ______________________ Phone Number: ______________

NWPT does not bill third parties or at fault carriers, as a courtesy we bill your personal auto and health insurance policies

If you have an attorney representing you, please provide their information below:

Attorney's Name: ______________________ Attorney's Phone: ______________

Address of Attorney: ______________________ City, State Zip: ______________

If treatment information needs to be communicated to your attorney, please fill out a NWPT Medical Records Release form.

Financial Policy

NWPT bills your insurance company as a courtesy and you are personally responsible for all balances after your insurance payments, denials and all non-contracted insurance balances. It is your responsibility to obtain any necessary referrals or authorizations required by your health plan. You are responsible to provide NWPT with the information necessary to bill your health insurance(s), including your current insurance card(s) and personal identification. You accept responsibility for balances not paid by your insurance.

Contracted Insurance Plans: NWPT is contracted with most insurance carriers. If we are contracted and participating with your primary or secondary insurance carrier, as a courtesy, we will bill them directly on your behalf and accept their payment. Any co-payments, co- insurance and/or deductibles determined as your responsibility must be paid in full.

Non-Contracted Insurance Plans: If you are insured through a company NWPT is not contracted with we will submit claims as a courtesy as long as all billing information is provided prior to services being rendered. It is important to note that if your insurance carrier(s) considers our facility or therapists Out-of-Network (OON) you may be charged a higher cost share by your insurance company. Any balance unpaid and remaining after 60 days will become your responsibility.

Auto Insurance: For motor vehicle incident/accidents, we will bill your PIP insurance. If you do not have PIP coverage or if you have exhausted your PIP coverage, as a courtesy we will bill your personal health insurance. Any liability deemed by your personal health insurance must be paid in accordance to this agreement. If you do not have personal health insurance to bill once your PIP has exhausted, any unpaid and remaining balance will become your responsibility.

Third Party or At-Fault Insurance: NWPT does not bill third party or at fault insurance carriers.

No Insurance Coverage: NWPT does provide a discount for services paid in full at the time of service.

No Shows/Late Cancellations: NWPT may charge a $45.00 fee for failing to keep an appointment or canceling 24 hours prior to scheduled appointment.

Co-payments: Required by your insurance plan are ***DUE AT THE TIME OF SERVICE***. If NWPT is required to bill you for co-pays, a $15.00 service fee per instance, may be applied to your account. You may choose to reschedule your appointment if you are unable to pay your co-pay at the time of service to avoid the $15.00 service fee.

Patient Statements: NWPT bills monthly any balance owed for deductibles, coinsurances or non-covered services. The balances on the statements are to be paid in full to NWPT upon receipt of the monthly statement. If you are unable to pay your balance at the time they are due, please contact our Billing Office at 800-478-2778 to set up a payment plan.

Returned Checks: NWPT charges a $25.00 NSF – Non-Sufficient Funds fee for all returned checks.

Additional Costs: I understand that I will be responsible for any additional cost related to NWPT's attempt to recover payment to include but not limited to attorney costs, court costs, lien fees, collection cost, etc.

I have read the above Financial Policy and agree that (regardless of insurance status) I am ultimately responsible for the balance of my account, or my dependents, for any professional services rendered by NWPT.

Assignment and Release of Information

I, the undersigned, consent to physical therapy procedures prescribed by my physician at the discretion of my physical therapist. I have verified the insurance company information provided to NWPT prior to my treatment and listed on my personal "Insurance Verification" report is accurate. Northwest Physical Therapy (NWPT) has my authority to release any medical information or records to the insurance company listed to help process my claims. I understand that my signature authorizes NW PT to submit claims for services without my signature on each and every claim. I also agree and authorize my insurance company to pay NWPT directly for services rendered.

Patient Consent to Treat Form

Our Notice of Privacy Practice provided information about how Northwest Physical Therapy may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before you sign this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to these restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Northwest Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. *Protected health information may be used and disclosed for treatment, payment and health care operations.*
2. *NWPT has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.*
3. *NWPT reserves the right to change the Notice of Privacy Practice.*
4. *The patient has the right to restrict the uses of their information but NWPT does not have to agree to those restrictions.*
5. *The patient may revoke this consent to disclose in writing at any time and all future disclosures will then cease.*

This consent was signed by:

Signature: ______________________________ *Date:* ____________________

Printed Name – Patient or Representative: ______________________________

Relationship to the patient (if other than patient): ______________________________

The signer of this document is assuming financial responsibility for this treatment.

The NWPT team would like to thank you for making us your preferred family physical therapist and health care provider. We are committed to your treatment being successful. We would like to know how you heard about us, please circle one of the following:

Family	Friend	Insurance Referral	Doctor	NWPT Website	NWPT Employee
Former Patient	Local High School	Local College	Yellow Pages	Newspaper	Other

If you would like to receive electronic communication, please provide your email address: ____________________