Sammamish Physical Therapy
22840 NE 8th Street, Suite 102
Sammamish, WA 98074
Phone: 425-898-8540 Fax: 425-898-1570

ACCOUNT INFORMATION (Person Responsible For Payment)

Name:_____ Date Of Birth:_____ Sex: (Circle One) M F

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Email Address:_____ Social Security Number:_____

Employer:_____ Employment Status: (Circle One) Full-Time Part-Time Retired Not Employed

Marital Status: (Circle One) Married Single Widowed Divorced Other

PATIENT INFORMATION (If Different From Above)

Name:_____ Date Of Birth:_____ Sex: (Circle One) M F

Street Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Email Address:_____ Social Security Number:_____

Employer:_____ Employment Status: (Circle One) Full-Time Part-Time Retired Not Employed

Marital Status: (Circle One) Married Single Widowed Divorced Other

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship To Patient:_____ Phone:_____

Referring Provider:_____ Primary Care Practitioner:_____

How Did You Hear About Sammamish PT?_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder Name:_____

Policy Holder Date Of Birth:_____

Policy Holder Employer:_____

Relationship To Patient:_____

SECONDARY INSURANCE

Policy Holder Name:_____

Policy Holder Date Of Birth:_____

Policy Holder Employer:_____

Relationship To Patient:_____

Is This A Work-Related Injury? ___Yes ___No Injury Date:_____ Claim Number:_____

Is This An Auto-Related Injury? ___Yes ___No Injury Date:_____ Claim Number:_____

Claims Address:_____ Claims Manager Name/Phone:_____

RELEASE & ASSIGNMENT

I, the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to Sammamish Physical Therapy all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance and any balance remaining after 60 days. Overdue accounts will be late-charged at 1.5% per month or a minimum of $10 per month billing fee. There will be a $30 return check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan is in-network. I realize that you have verified this, however, that it is not a guarantee of benefits or payments.**

_____

Patient Signature (if under 18, parent/guardian must sign) **Date**

Sammamish Physical Therapy & Sports Rehab Clinic

Late Cancellation & No-Show Policy

It is the policy of Sammamish Physical Therapy & Sports Rehab Clinic to request appointment changes or cancellations at least **24 hours before your scheduled appointment time.**

If you cancel after that time or fail to attend a scheduled appointment, you will be charged the full appointment fee. Payment of this fee is due at the time of your next appointment.

If you do not cancel your appointment with at least a 24 hour notice there will be a $120 charge to you. This charge will be an out-of-pocket expense and is not reimbursable by your insurance. Patient Initials:_____

If you cancel 3 scheduled appointments less than 24 hours notice you will be put on same-day status (all future appointments may be made on the same day only).

If late arrivals to scheduled appointments become a chronic occurrence, we reserve the right to cancel upcoming appointments and offer them to patients who are more committed to their physical therapy treatment program.

Printed Name:_____

I understand that in order to enter into a patient-practitioner contract, Sammamish Physical Therapy & Sports Rehab Clinic requires that I agree to the terms of the late cancellation and no-show policy.

_____

Patient Signature (if under 18, parent/guardian must sign) **Date**

MEDICAL HISTORY FORM

1. Name

Last	First	MI

2. Are you: ☐ Right-handed ☐ Left-handed

3. Employment

☐ Work outside of home ☐ Student
☐ Homemaker ☐ Retired
☐ Unemployed
Occupation: _____

How many hours do you spend in computer/desk work per day?_____

How much and how often do you lift objects heavier than 10 pounds?
# of times/day: _____
Average weight of objects lifted: _____

4. Where do you live?

☐ Private home ☐ Private apartment
☐ Board & care / assisted living / group home
☐ Other _____

5. With whom do you live?

☐ Alone ☐ Spouse
☐ Child ☐ Other relative
☐ Pets ☐ Other _____
☐ Personal care attendant
☐ 24-hour ☐ Part-time

6. Does your home have:

☐ Stairs ☐ Ramps
☐ Elevator

7. Do you use:

☐ Cane ☐ Walker ☐ Other _____

8. Do you have any vision or hearing problems? ☐ Yes ☐ No

Do you use:
☐ Glasses/Contacts ☐ Hearing Aid

9. Medications

Do you currently take any prescription medications?
☐ Yes ☐ No If yes, please list: _____
_____
_____
_____

Do you currently take any nonprescription medications?

☐ Antacids ☐ Ibuprofen/ Naproxen
☐ Antihistamines ☐ Laxatives
☐ Aspirin ☐ Tylenol
☐ Decongestants ☐ Vitamins
☐ Herbal supplement

Other _____

10. Health Habits

Please rate your health:
☐ Excellent ☐ Good
☐ Fair ☐ Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?
☐ Yes
Please describe the exercise, sport or hobby: _____
_____
_____
How many days per week do you exercise or do physical activity? _____
For how many minutes, on an average day? _____
☐ No

Do you currently use or have you previously used tobacco?
☐ Yes Cigarettes, # of packs/day _____
Cigars, # per day _____
Chewing tobacco_____
Year quit: _____
☐ No

How many days per week do you drink beer, wine, or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day? _____

Do you have a history of chemical dependency?
☐ Yes ☐ No

11. Within the past year, have you had any of the following medical tests?

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Pulmonary function test
☐ Stress test (such as treadmill, bicycle)
☐ X-rays

Therapist comments: _____
_____
_____
_____

Therapist signature: _____

CONTINUE ON OTHER SIDE

12. Medical History

Please check if you have had:	**Yes**	**No**
Allergies		
Arthritis		
Bladder problems (including repeated infections, urinary incontinence, leaking)		
Blood disorders (including hemophilia/anemia)		
Bone/joint infections		
Broken bones/fractures		
Cancer		
Circulation/vascular		
Depression		
Developmental or growth problems		
Diabetes or problems with blood sugar		
Fibromyalgia		
Head injury		
Heart problems (Pacemaker)		
High blood pressure		
Infectious diseases (such as tuberculosis, hepatitis, HIV)		
Kidney problems		
Liver problems		
Lung problems (including asthma)		
Metal implants		
Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)		
Osteoporosis		
Seizures/epilepsy		
Sensitivity to latex rubber		
Skin diseases		
Thyroid problems		
Ulcers/stomach problems		
Other: _____.		

For men:

Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No

For women:

Have you ever been diagnosed with:

☐ Pelvic inflammatory disease? ☐ Endometriosis? ☐ Trouble with your period?

☐ Complicated pregnancies/deliveries?

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

13. Have you ever had surgery?

☐ Yes ☐ No

If yes, please describe and include dates: ____

_____

_____

_____

14. Within the past year, have you had any of the following symptoms?

☐ Bowel problems
☐ Chest pain
☐ Coordination problems
☐ Chronic cough
☐ Difficulty sleeping
☐ Dizziness or blackouts
☐ Fever/chills/ sweats
☐ General malaise
☐ Headaches
☐ Hearing problems
☐ Heart palpitations
☐ Hoarseness
☐ Loss of appetite
☐ Loss of balance or falls
☐ Nausea/ vomiting
☐ Pain during the night
☐ Sexual dysfunction
☐ Shortness of breath
☐ Urinary problems or change in frequency
☐ Vision problems
☐ Weakness in arms or legs
☐ Weight loss/gain

15. Are you currently seeing anyone else for this diagnosis?

☐ Acupuncturist
☐ Athletic trainer
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family doctor
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/ gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other _____

If you see another health professional for this problem, may the physical therapist discuss your case with him or her? ☐ Yes ☐ No

Patient Signature: _____

Date: ____/____/____

Therapist comments: _____

_____

_____

_____

Therapist signature: _____

CONSENT TO USE AND/OR DISCLOSURE OF PATIENT INFORMATION

As a patient of **Sammamish Physical Therapy and Sports Rehab Clinic**, you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of Patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practices before signing this form. A copy of this Notice was made available to you along with the Consent. If you do not have a copy of the Notice you can request one from us at the address and phone number given below.

We may change our Notice of Privacy Practices from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you come in for an appointment. You may obtain a copy of our current Notice upon request to our address and phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care; and conduct certain kinds of administrative health care operations. By signing this Consent below, you agree that we may use or disclose information about you for these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number given below if you want more information or to request additional restrictions.

You have the right to revoke this Consent at any time, but must do so in writing. A revocation of this Consent will not apply to any use or disclosure of information which happened before we received your written revocation. Please contact us at the address and phone number below if you want more information, or to revoke this Consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

I am also authorizing Sammamish Physical Therapy and Sports Rehab Clinic to leave detailed messages on my answering machine. _____
Please initial

I authorize Sammamish Physical Therapy to release or not release information to:

(circle one)

_____
Name/Relationship to patient

_____
Name of Patient

_____
Patient Signature Date

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