BIOJUNCTION
Sports Therapy™
Lora Clothier, DPT - Owner

Dear New Patient,

Thank you for choosing Biojunction Sports Therapy. We look forward to meeting you!

Enclosed you will find some information that will help you to know us, and us to better know about you and the reason that you are visiting our clinic. It is helpful if these forms are fully completed prior to the start of your first appointment.

Please bring the following to your first appointment:

- All completed registration and medical history forms.
- Your doctor's written prescription, if required by your insurance.
- Your insurance card and photo ID so that we may photocopy the necessary information.
- Comfortable clothing, preferably that will allow easy access to the body part being treated.

If you are being evaluated for orthotics, please also bring:

- A selection of the shoes you wear daily and/or are active in (sport shoes, work shoes, etc.).
- A pair of shorts or pants which can be rolled above the knee.

Please plan to spend 45 to 60 minutes for your initial evaluation. Should you have any questions regarding your appointment, feel free to call our office at (206) 938-0860.

Thank you!

3727 California Ave SW, Suite 1-A • Seattle, WA 98116 • Phone: 206.938.0860 • Fax: 206.938.0866
Email: lora@biojunctionsportstherapy.com • Website: www.bio-junction.com

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PATIENT & INSURANCE INFORMATION

Patient Information:

First Name_____Middle I._____Last Name _____

If patient is a minor - Father's name _ Mother's name _

Address_____Apt. _____

City_____State_____Zip_____

M___F_____ Birthdate _____ E-mail (for appointment reminders) _____

Home Ph_____Work Ph_____Cell Ph _____

Preferred number Home____ Work____ Cell____ OK to leave detailed message____

Emergency contact: Name_____Phone _____

Referring Doctor:_____Dr. Phone _____

Primary Doctor:_____Dr. Phone ____

Who may we thank for referring you? Physician/health care provider Internet Neighborhood Newspaper

___Friend / family _____ ___Other _____

Insurance Information: *Complete this section only if you are unable to provide a copy of your insurance card.

Primary Insurance: *(Please let us know if you are covered by more than one insurance company.)*

Insured's Name_____Birthdate_____

Insurance Co._____Cust. Service Phone _____

Member ID#_____Group # _____

Was your injury the result of a WORK or AUTO accident? If so, please provide insurance info above AND complete this section:

Claim #_____Date of Injury_____

Claims Manager_____Claims Mgr phone _____

Insurance Carrier_____Claims Address _____

Billing Information: Bill to patient address above _____ OR Bill to responsible party below _____

Name_____Phone _____

Address _____

City_____State_____Zip_____

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:
I understand, as the patient and/or above-mentioned responsible party, that I am fully responsible for payment of all charges incurred, including any deductibles, non-covered services, or non-authorized services. I assign all medical payment to Biojunction Sports Therapy.

I hereby authorize the release of any medical information necessary to secure payment for services rendered.

Patient Signature_____ Date:_____
(*Parent or guardian, if patient is minor)*

CONFIDENTIAL
MEDICAL INFORMATION

1. Please state your current problem(s) _____

_____

2. Describe how and when your symptoms began *(Give specific date, if applicable)*: _____

_____

3. On a scale of 0-10, with 0 being "No pain at all" and 10 being "Worst pain imaginable", for the last week please rate your level of discomfort: At **WORST**_____/ 10; At **BEST**_____/ 10; What is it **CURRENTLY**:_____/ 10

4. What aggravates your symptoms? _____

5. What eases your symptoms? _____

6. Have you had any special tests regarding your symptoms (MRI, X-Ray, CT Scan, Ultrasound, etc…)? Y N

If yes, results? _____

7. Allergies _____

8. Current medication _____

9. Major surgeries since birth _____

_____

10. Are you currently being treated by:

Another physical therapist	Yes ____	No ____	Or within the last 12 months	Yes ____	No ____
Chiropractor	Yes ____	No ____	Or within the last 12 months	Yes ____	No ____
Massage Therapist	Yes ____	No ____	Or within the last 12 months	Yes ____	No ____
Acupuncturist	Yes ____	No ____	Or within the last 12 months	Yes ____	No ____
Other_____	Yes ____	No ____	Or within the last 12 months	Yes ____	No ____

11. Do you currently have or have you had a history of the following:

___AIDS	___Circulation Problems	___Seizures
___Arthritis	___Depression	___Stroke
___Artificial Joints	___Diabetes	___Ulcers
___Asthma	___Heart Condition	___Other _____
___Cancer	___High Blood Pressure	_____

The above information is true and accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Biojunction Sports Therapy to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of the presenting physical condition(s) to the patient named above.

Patient Name:_____

Patient Signature:_____ Date:_____

(*Parent or guardian, if patient is minor)*

FINANCIAL POLICY STATEMENT

Insurance Billing –

- As a courtesy to our patients, we will bill your insurance(s) based on the information you provide.
- All copays are due at time of service. Other costs (e.g., deductible, co-insurance) will be billed to the patient or responsible party after the insurance has processed your claims.
- Please be advised that it is your responsibility to know the limitations and/or restrictions of your insurance company/plan regarding physical therapy treatment and orthotics. We recommend that you contact your insurance company prior to your first appointment to verify your coverage for outpatient physical therapy, and to determine if your plan requires a prescription or referral from your physician.

Please understand that you are financially responsible for any deductibles, co-pays, and non-covered, or non-authorized services.

No Show/Cancellation Policy

- Please give one full business day's (minimum 24 hours) notice in advance to cancel an appointment to avoid a cancellation charge of **$50.00**.
- This charge cannot be billed to your insurance.

Interest Charge/collections fees

- Any balance remaining after 60 days from the billing date will incur an interest charge at the rate of 1% per month, 12% annually.
- If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

For L&I Claims:

- Be advised that you may be responsible for your charges if your Workers' Compensation claim is closed or denied.
- If you miss two (2) scheduled appointments without 24 hours notification, your claims manager will be contacted and you may be held responsible for the No Show fee(s).

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name:_____

Patient Signature:_____ Date:_____

(*Parent or guardian, if patient is minor)*

NOTICE OF PRIVACY PRACTICES (Required by law)

Biojunction Sports Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20,2000.

- We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

- Our clinical and front office staffs use patient information to ensure quality care and appropriate billing for services.

- You may correct, amend, access, and request a copy of your medical records and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

- We protect all patient information within the guidelines provided by federal, state, and local government.

- If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 206-938-0860.

- Biojunction Sports Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations, and guidelines.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.

Patient Name:_____

Patient Signature:_____ Date:_____

(*Parent or guardian, if patient is minor)*