

Personal Information

Patient Name _____ Mr. Ms. Miss Mrs. Dr.

 Last First Middle
 Address _____

 City State Zip
 Employer/Occupation _____
 Birth Date _____
 Soc. Sec. # _____
 Marital Status Single Married Other
 Spouse's Name _____

Today's Date: _____
 Home Phone (____) _____ - _____
 Work Phone (____) _____ - _____
 Mobile Phone (____) _____ - _____
 Which Phone do you prefer we contact? _____
 Email _____

Would you like reminder e-mails of appointments? Yes No
 Would you like to receive statements via e-mail? Yes No
 Would you like to receive our clinic's newsletter sent
 once every 3 weeks? Yes No

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Nature of Injury/Symptom

Whom may we thank for referring you to this clinic? _____
 Did you receive a written referral or prescription for physical therapy?
 No Yes, from (Name/Location) _____
 Primary Care Physician/Location _____
 Date of Injury / Symptom _____ Body Part Involved (If applicable) _____ right or left

Insurance Information

Name of **Primary Insurance** Company _____
 Relationship to Insured (Circle) Self Spouse Child
 If not Self, Primary Cardholder's Name: _____ Date of Birth _____

Name of **Secondary Insurance** Company _____
 Relationship to Insured (Circle) Self Spouse Child
 If not Self, Primary Cardholder's Name: _____ Date of Birth _____

If Child, Primary Cardholder's Address: _____ Phone Number _____

Labor and Industry Claim (Worker's Comp)

Date of Accident _____ Claim Number _____
 Employer Information: Name of Company: _____
 Address: _____
 Phone Number: _____

Motor Vehicle Accident Claim (PIP)

Date of Accident _____ Claim Number _____
 Insurance Company or Attorney's Office to bill: _____
 Claims/Billing Address _____

Assignment and Release: I hereby assign to Pacific Balance and Rehabilitation Clinic, PLLC ("PBRC") any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to PBRC for services provided by PBRC. I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by PBRC, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 30 days of the monthly billing date a finance charge will be added to the account of 1% per month which is an annual percentage rate of 12%. The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

Signature of Patient

(or patient's authorized representative)

Relationship/ Status if signed by anyone other than the patient
(e.g. parent, legal guardian, personal representative)

Date

Acknowledgement of Receipt of Privacy Practices Notice

I have been presented with a copy of Pacific Balance and Rehabilitation Clinic’s **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Consent to be Contacted Regarding Appointments or Account Information

We at Pacific Balance and Rehab are working hard to ensure that confidentiality regarding your Protected Health Information and treatment is maintained at all times. Due to confidentiality concerns and to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we require your signature allowing us to contact you about your upcoming office visit, account information, or any other information you may want us to convey to you via telephone or e-mail.

Financial Policy

It is your responsibility to know the limitations and restrictions of your insurance company regarding physical therapy. You are responsible for paying your balance regardless of your insurance company’s payments. If your insurance company does not cover physical therapy and you opt to pay cash for treatment, your balance is due at the end of your appointment. Delinquent accounts will be charged a 1% interest fee for every 30 days past due, beginning at 60 days past due. This fee will be added to your monthly billing statement.

Canceling or Rescheduling Appointments

If you find the need to cancel or reschedule your appointment, please contact us within **24 hours** of your scheduled appointment to avoid a **late cancellation fee of \$50** per missed appointment. These charges cannot be billed to your insurance company and will be your responsibility.

Co-Pays

The front desk staff will verify your health insurance benefits to verify if your plan requires a co- pay. If so, **co-pays are due at the time of each visit.**

Note: Clients with Medicare, Medicaid (DSHS or Provider One) or with Labor & Industries or Personal Injury Protection Claims (Auto Accident Claims) do not require a co-pay.

Please approach a front desk staff member if you have any questions on these policies.

By signing below, I am acknowledging that I have read, understood, and agree to all of the above policies.

Patient Signature

Parent / Guardian Signature

Date

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past, and please check if you have a family history.

Self	Family		Self	Family	
_____	_____	Chest Pain	_____	_____	Osteoarthritis
_____	_____	Heart Disease	_____	_____	Rheumatoid Arthritis
_____	_____	High/Low Blood Pressure	_____	_____	Hepatitis
_____	_____	High Cholesterol	_____	_____	Blood Clots
_____	_____	Poor Circulation	_____	_____	Diabetes
_____	_____	Difficulty Breathing	_____	_____	Bleeding/Bruising Easily
_____	_____	Tuberculosis	_____	_____	Hearing Impairment
_____	_____	Respiratory Disease	_____	_____	Visual Impairment
_____	_____	Numbness to Hands and Feet	_____	_____	Skin Rash/Disease
_____	_____	Head Injury	_____	_____	Dizziness
_____	_____	Stroke	_____	_____	Cancer
_____	_____	Seizures	_____	_____	Allergies
_____	_____	Difficulty with Balance	_____	_____	Osteoporosis
_____	_____	Frequent Falls	_____	_____	Bowel/bladder Problems
_____	_____	Blackouts	_____	_____	Headaches

Have you experienced any of the following in the past 3 months?

Change in health	Yes	No	Change in appetite	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No
Fever/chills/sweats	Yes	No	Night pain	Yes	No
Unexplained weight change	Yes	No	Unusual fatigue	Yes	No

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ If so, how often? _____

Do you get short of breath with exertion (up/down stairs)? _____

Women, is there any chance of pregnancy? _____

Do you have any other orthopedic injuries? _____

Please list any surgeries or hospitalizations: _____

Please list (or bring in a copy of) any medications or supplements you are currently taking: _____

Do you have any other special problems/concerns we should know about?

Patient Signature

 Parent / Guardian Signature

Date

****VESTIBULAR PATIENTS EXPERIENCING DIZZINESS OR IMBALANCE ONLY
MAY DISREGARD THIS PAGE IF NOT APPLICABLE****

On the scales below, please circle the number which best represents the severity of your pain.

Currently:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Least amount of pain in the last 48 hours:

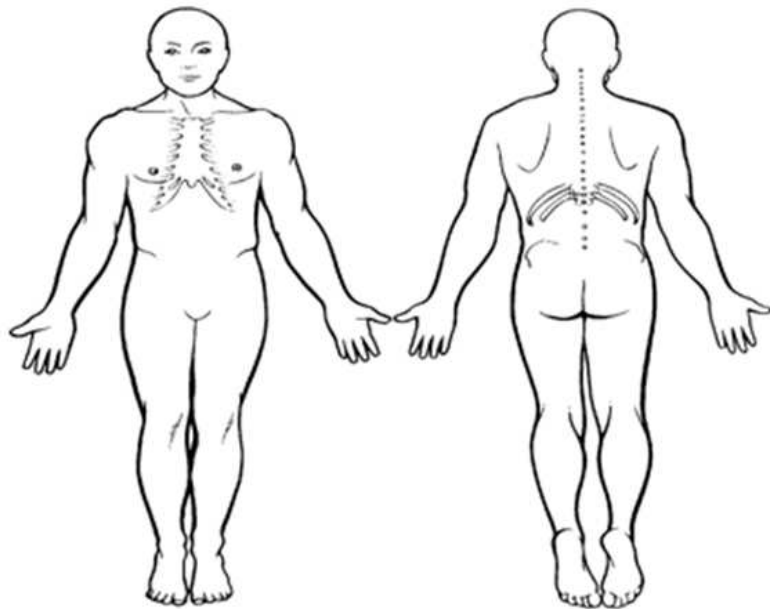
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Most amount of pain in the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



Please circle the number below which best represents your **overall average level of function**.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better? _____

During the past month, have you been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

- 1) _____
- 2) _____
- 3) _____