



Parent / Guardian/ Financially Responsible Party (Please Print)

Name _____ Phone () _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Email: _____

FOR BILLING QUESTIONS/ CONCERNS/ INVOICES/ UPDATES

How do you want to receive appointment reminders? Select 1: Text Phone Call Email

Who may we thank for referring you? Please Indicate Whom _____

Patient Information (Please Print)

First Name _____ MI _____ Last Name _____ DOB _____

Sex (required for insurance purposes): Male Female

Gender if different from sex (optional): Transgender Gender Fluid Non-Binary Other _____

Pronoun Preference (optional): he/ him/ his she/ her/ hers they/ them/ theirs Other _____

Emergency Contact (Please Print) REQUIRED

Name _____ Relationship _____ Phone _____

Problem

Referring Provider _____ Primary Care Physician _____

Injury/ Body Part Involved _____ Right Left

Last MD Visit _____ Have you previously been treated by a Physical Therapist this year? Yes No

Insurance Information REQUIRED

Primary Insurance _____ Secondary Insurance _____

REQUIRED

REQUIRED or indicate none N/A

Subscriber Name _____ Subscriber Name _____

REQUIRED

REQUIRED or indicate none N/A

Subscriber DOB _____ Subscriber DOB _____

REQUIRED

REQUIRED or indicate none N/A

Relationship to Subscriber _____ Relationship to Subscriber _____

REQUIRED

REQUIRED or indicate none N/A

ID # _____ Group # _____ ID # _____ Group # _____

REQUIRED

REQUIRED

REQUIRED or indicate none N/A

REQUIRED or indicate none N/A

I am not providing insurance information. I am private paying for my sessions.

Agreement

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service **and I am financially responsible for non-covered services.** I also authorize Innova Physical Therapy to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care.

I understand that the designated Parent/ Guardian is REQUIRED to be present for the entire duration of the initial evaluation treatment session. Innova invites but does not require parent/guardian attendance at all sessions.

Signature of Parent/ Guardian of minor patient: _____ Date _____

PRINTED name of Parent/ Guardian of minor patient: _____

Name: _____

Height: _____

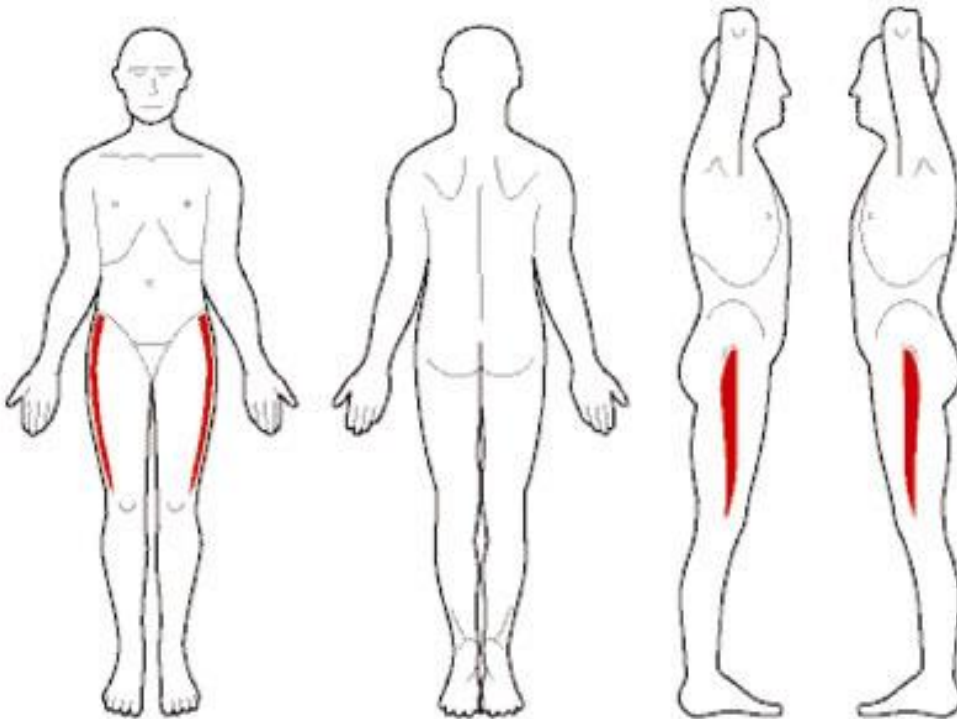
Weight: _____

PERSONAL HEALTH HISTORY

What problem/ issue brings you here today? _____

Mark the areas of the body where you feel pain. Include all affected areas. Use the appropriate symbols.

ACHE >>>> **NUMBNESS** //// **PINS & NEEDLES** oooo **STABBING** ++++ **BURNING** xxxx



Please check the appropriate box to describe the level of pain/ discomfort you are having today.

0= No pain

10= Worst pain imaginable

- 0 1 2 3 4 5 6 7 8 9 10

When did your injury begin? _____

Please describe the timing of your pain:

- Constant Comes and Goes Getting Worse Getting Better Keeps Me Awake

What activities aggravate your injury/problem area? _____

What activities relieve your injury/problem area? _____

My current exercise program includes: _____

Do you have a history of falling? Yes No

Have any injuries that resulted from a fall? Yes No

How often do you fall/ per week? _____

When was your last fall? _____

REQUIRED

Please list three activities you are unable to do or are having difficulty with as a result of your problem:

Activity

1= Unable to perform activity

10= Able to perform activity as before problem

1. _____ 1 2 3 4 5 6 7 8 9 10

2. _____ 1 2 3 4 5 6 7 8 9 10

3. _____ 1 2 3 4 5 6 7 8 9 10

Have you had any of the following tests:

Bone Scan MRI XRAY EMG CT Scan Blood Work Injections

Other: _____

Have you received treatment for your current condition? Yes No

Physical Therapy Massage Therapy Chiropractic Acupuncture

Injection: _____ **Date:** _____ **Location:** _____

Prior Surgery: REQUIRED *If none, indicate N/A*

TYPE	DATE

Medications: REQUIRED *If none, indicate N/A*

NAME	DOSAGE

Please check as many of the following conditions apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Imbalance/ Frequent Falls | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Severe Night Pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Rash/ Disease |
| <input type="checkbox"/> Bleeding/ Bruising Problem | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Chills | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Persistent or Unusual Cough | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Head Injury/ Concussion | <input type="checkbox"/> Numbness to Hands or Feet | <input type="checkbox"/> Unusual Stress at Home |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Visual/ Hearing Problems | <input type="checkbox"/> Unusual Stress at Work |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Bowel/ Bladder Problems | |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Arteriosclerosis | |

Work:

Job Title _____ Employment Status _____

How physically demanding is your job? Sedentary Light Moderate Heavy

Patients who are faced with daily pain commonly experience worry, frustration and sadness. Please check the appropriate box to indicate the extent that you are troubled by the following:

Emotional Status

0= NONE

10= SEVERE

Anxiety 0 1 2 3 4 5 6 7 8 9 10

Depression 0 1 2 3 4 5 6 7 8 9 10

Irritability 0 1 2 3 4 5 6 7 8 9 10

Did you experience anxiety or depression prior to the problem in which we are seeing you for today? Yes No

Have you received counseling for anxiety or depression? Yes No

Do you have a history of psychological disease? (ie: ADD, OCD, Bipolar, Schizophrenia) Yes No

Would you like to share any other information with us today? _____

I voluntarily give my permission to Innova Physical Therapy to provide therapy services and treatment to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Innova Physical Therapy, or until I withdraw my consent in writing.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____



AUTHORIZATION AND CONSENT TO TREAT A MINOR

Standard Clinic Policy:

Innova treats patients of all ages in a safe and respectful manner. To provide the highest-level care, promote lasting efficacy of treatment, and ensure safety, **Innova requires that minors are accompanied by their parent/guardian for at least their initial evaluation session.** This is not only to promote compliance in Home Exercise Programs and accuracy in medical history and reporting, but to also safeguard the patient and the provider from miscommunication or misunderstanding.

**Innova invites but does not require parent/guardian attendance at all sessions.
This policy is an important part of Innova’s mission to provide a safe environment for patients.**

Treatment:

Physical Therapy treatment consists of but is not limited to therapeutic exercise, modalities, and manual therapy.

The undersigned does hereby authorize Innova Physical Therapy consent to treat and reassess the mentioned minor by employees of Innova Physical Therapy without a parent or guardian present as consistent with the standard practices of Physical Therapy outlined by Washington State Law.

Date: _____

Patient/ Minor: _____

Parent /Guardian: _____

Witness: _____

Any special considerations or additional medical information for the named minor’s treatment?



FINANCIAL POLICY

Standard Insurance Policy:

Innova will bill your insurance carrier as a courtesy to you. However, you are ultimately responsible for payment for services you receive. If we are contracted with your insurance company, we must follow our contract and their requirements. **It is the insurance company that makes the final determination of your eligibility.**

Costs you may be responsible for after insurance processes:

- Deductible**
- Copayments**
- Non-Covered Services**

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company. Referrals are current for 90 days unless otherwise specified.

Copays are due at the time of service. It is your responsibility to know the amount of your copay. My copay is \$ _____ .

The balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the due date on the statement. Payment plans are available upon request.

Self-Pay Policy:

Innova will apply a discount for patients without insurance coverage, or for those patients that have exceeded insurance benefits. Payment is due at the time services are rendered.

Auto PIP/ Third Party Policy:

We do not accept third-party or accident settlement *liens*. If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your health insurance or pay our self-pay rates at the time of service.

Cancellation Policy:

The appointments made for you represent a time set aside specifically for you and your therapist. We value your time and ask that you value ours by giving at least 24 hours' notice for any cancellations or changes to your appointment.

Patients who fail to provide **24 hours' notice** will be charged a **\$60.00 fee**. This fee is not billable to insurance and is due at your next scheduled appointment. Patients who cancel or no show on three separate occasions will be discharged from physical therapy and removed from the schedule. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge.

If you have any questions regarding this policy, please do not hesitate to contact our *Clinic Director* at: (425) 658-4980

I understand the Financial Policies as described above. I acknowledge that I am financially responsible for any balance due on covered or non-covered services.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____



PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act (HIPAA). I have been given the right to review and receive a copy of InnoVA's Notice of Privacy Practices. I understand that InnoVA Physical Therapy will use or disclose my health information for treatment, billing and healthcare operation. I understand that I have the right to request in writing how my private information is used or disclosed.

Signature (Parent/ Guardian if patient is a minor) _____ Date _____