



# Deer Park Physical Therapy & Sports Conditioning

707 South Park  
Deer Park, WA 99006

## PATIENT INFORMATION

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Spouse / Parent / Guardian \_\_\_\_\_  
Last First Middle Initial

Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Street Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Birth Date \_\_\_\_\_

Sex  M  F Marital Status  S  M  W  D SS# \_\_\_\_\_ Email \_\_\_\_\_

Employed By \_\_\_\_\_ Work Phone \_\_\_\_\_

CONTACT

Emergency Contact- Local Relative or Friend **NOT LIVING WITH YOU.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

FINANCIAL RESPONSIBILITY

**If patient bill is to be paid by Someone Other than Patient, please complete this information.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employed By \_\_\_\_\_ City \_\_\_\_\_

INSURANCE

**Private Pay - Primary Insurance**  Medical  Auto  Work

**Secondary Insurance**  Medical  Auto  Work

Have been treated with physical therapy in the last 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Injury \_\_\_\_\_

Company \_\_\_\_\_ Company \_\_\_\_\_

Claim / Subscriber / ID# \_\_\_\_\_ Claim / Subscriber / ID# \_\_\_\_\_

Adjuster \_\_\_\_\_ Phone \_\_\_\_\_ Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Attorneys Name \_\_\_\_\_ Phone \_\_\_\_\_

RELEASE OF INFORMATION

**Authorization To Release Information:** I authorize the following family members, friends, caregivers, etc to be able to speak with DPPT & SC on my behalf for any and all parts of my physical therapy treatments, scheduling, billing, and public program. This authorization will expire in 90 days.

\_\_\_\_\_

\_\_\_\_\_

DISCLOSURE

### DEER PARK PHYSICAL THERAPY & SPORTS CONDITIONING NOTICE OF PRIVACY PRACTICES

I have reviewed and/or been given the option to receive a copy of the Deer Park Physical Therapy & Sports Conditioning Notice of Privacy Practices. I know the terms of this notice and have been advised I can review it again at any time as I request.

I LEARNED OF DPPT&SC...

I learned of Deer Park Physical Therapy & Sports Conditioning through:  Doctor: \_\_\_\_\_  Friend/Relative: \_\_\_\_\_  Returning Patient

AD IN:  Outpost Ad  Tribune  Town & Country  Sign on Building  Bi-Mart Pharmacy Bag  Other Publication: \_\_\_\_\_

School  Open House  Other: \_\_\_\_\_

**AGREEMENT OF TERMS ON REVERSE SIDE - REVIEW AND SIGNATURE REQUIRED**



# Deer Park Physical Therapy & Sports Conditioning

This is an agreement between **Deer Park Physical Therapy & Sports Conditioning** and the patient named on this form. By executing this agreement, **you are agreeing to pay for all services and supplies that are received regardless of litigation, insurance reimbursement, pending worker's compensation, auto insurance settlement or other third party settlement.**

**Attendance:** A plan is established between you, your therapist, and your doctor. Your scheduled appointment is set aside for you. If you arrive late your treatment will end at its scheduled time so the next patient will be seen at their scheduled time.

**Cancellation & No Show:** Cancellations or changes to your appointment must be requested by closing the day prior to scheduled appointment time. If you are an injured worker, your healthcare provider and claims manager will be notified after two (2) consecutive cancellations and no-shows. Should three (3) cancellations or no-shows occur, Deer Park Physical Therapy will be unable to continue your treatment until you visit with your health care provider and bring back a new order. A fee of \$60 may be charged to your account and you will be required to pay this amount prior to your next visit.

**Qualify for Free Gym Use:** While receiving therapy, you are eligible for use of Deer Park Fitness Center after 5 PM. If you have not had a cancellation or no show during your treatment program you are eligible for a one month free use of the Fitness Center.

**Financial Policy:** Deer Park Physical Therapy will bill your primary insurance followed by your secondary insurance noted on the reverse page. As a courtesy to you, the billing office inquires about your benefits, however, benefits quoted are not a guarantee payment will be made by your insurance company. The insurance company makes the final determination of payment and eligibility. It is your responsibility to know your Outpatient Physical Therapy benefits and you assume full financial responsibility for our services. **Parent/Guardian:** You understand if you are the parent/guardian you are responsible for payment of services for the minor (less than 18) and must accompany the patient to their first appointment.

**Any co-payments or co-insurance required by an insurance company must be paid at the time of service. If policy deductible is over \$100.00 a \$35.00 payment will be made each visit until the deductible has been satisfied. Co-insurance of 10%=\$10.00; 20%=\$20.00; 30%=\$30.00**

If you are unable to comply with the above payment plan due to personal financial hardship, you may qualify for a monthly payment plan. To find out if you qualify, contact the billing specialist 590-4206.

**Finance Charge:** You understand finance charges of 1% per month, 12% per annum, will accrue on any unpaid balance over 60 days due and these charges will be included in the final bill.

**Medical Supplies:** Most medical supplies are not covered by your insurance. These must be purchased when dispensed. We accept cash, checks and credit cards.

**Payment Direct to Deer Park Physical Therapy & Sports Conditioning:** You authorize payment be made direct to **Deer Park Physical Therapy & Sports Conditioning** by the insurance company/third party payers.

**Returned Check Fee:** You agree to pay a fee of \$25.00 for any check returned by your financial institution regardless of reason.

**Referrals/Prescription/Authorization:** If your insurance company requires a prescription for physical therapy, it is your obligation to provide a copy to our clinic. Should you choose to have therapy before the referral/prescription/authorization is obtained, you understand you are responsible for payment of your therapy visit. **Self-Referral:** State laws provide **direct access** to licensed Physical Therapists without a physician's referral or prescription. You must check with your insurance plan to understand whether a physician order is required to pay for direct access.

**Workers Compensation:** **Deer Park Physical Therapy and Sports Conditioning** requires approval/authorization by your workers compensation carrier prior to your initial visit. If your claim is denied, payment shall be made by billing medical insurance and/or private pay. If your claim is in litigation, you must provide verification from your attorney and/or worker's compensation carrier of legal proceedings and monthly payments may be established.

**Personal Injury/Motor Vehicle Accidents /Involvement of an Attorney:** **Deer Park Physical Therapy and Sports Conditioning** will verify a claim or lawsuit by the claim number, adjuster and phone number. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill PIP as primary insurance and will bill your private health insurance secondly. **If your medical insurance policy denies the claim for any reason you are responsible for the full payment of your bill. A lien will be filed on any claim or lawsuit where your account has a balance owing, and you remain liable for the full payment of your bill. You understand the filing fees will be added to your account as your responsibility, and you must make monthly payments until settlement or other recovery pays your bill in full. You are not authorized to reduce the amount owed to us and you will instruct your legal representative accordingly.**

**Release of Information:** You authorize **Deer Park Physical Therapy & Sports Conditioning** to release to your insurance company/ third party payer any information necessary for payment of your medical claims. You understand employers or their authorized representatives may review any files of their own injured workers in connection with any workers compensation pending claims. (RCW 51.28.070) You further authorize release of information for continuity of care and for quality improvement by Deer Park Physical Therapy.

**Specific Authorization:** You specifically authorize, unless expressly limited by you in writing to us, to release information related to **medical diagnoses, procedures, testing and/or treatment that involve drugs and/or alcohol, sexually transmitted diseases, AIDS or HIV infection and or mental health to your insurance company/ third party payer.** You understand you have the right to restrict release of information by giving us this information in writing. Please ask for a form if needed.

12/01/2010

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Minor, Responsible Party Signature

\_\_\_\_\_  
Date