15404 E Springfield Ave, Ste L 202
Spokane Valley, WA 99037
Phone: 509-481-9363
Fax: 509-892-9998

Patient Information:

First Name: _____MI: _____ Last Name: _____

Address: _____

Apt._____ City: _____State:_____ Zip Code:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Sex: M / F **Date of birth**: _____ Age: ____ Employer: _____

Occupation:_____ E-Mail: _____

Emergency Contact # _____ Name/Relationship_____

Have you had physical therapy in the past? Yes_____ No_____ If yes please answer the following:

When did you receive treatment _____

What diagnosis did you receive treatment for _____

Doctor Information:

Referring Doctor (who wrote the Rx to come to therapy): _____

Referring Doctor Address: _____

Referring Doctor Phone: _____ Fax #_____

Date of the initial Rx: _____

Primary Doctor: _____ Phone _____

Insurance Information:

Primary Insurance

Insurance Co: _____**Ins ID #**_____

Is this the Patient's insurance? ___Yes ___ No If no, the name of the Insured_____

Insured's DOB: _____ Relationship to the patient: ____spouse ____ child ___other

Secondary Insurance

Insurance Co: _____**Ins ID** _____

Is this the patient's insurance? ___ Yes ___ No If not, who is the Insured? Name: _____

Insured's DOB: _____ Insured's relation to the patient: ___ child ___ spouse ___ other

Referred By: _____ How did you hear about us?_____

Patient Authorization Form

Patient Name (printed): _____

Release of Information & Consent for Treatment

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment at You Turn Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to You Turn Physical Therapy, LLC and its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize You Turn Physical Therapy, LLC and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Assignment of Benefits

I authorize payment directly to You Turn Physical Therapy, LLC., its subsidiaries and/or affiliates for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for You Turn Physical Therapy, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Payment Guarantee

I agree to pay You Turn Physical Therapy, LLC. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of You Turn Physical Therapy, LLC.

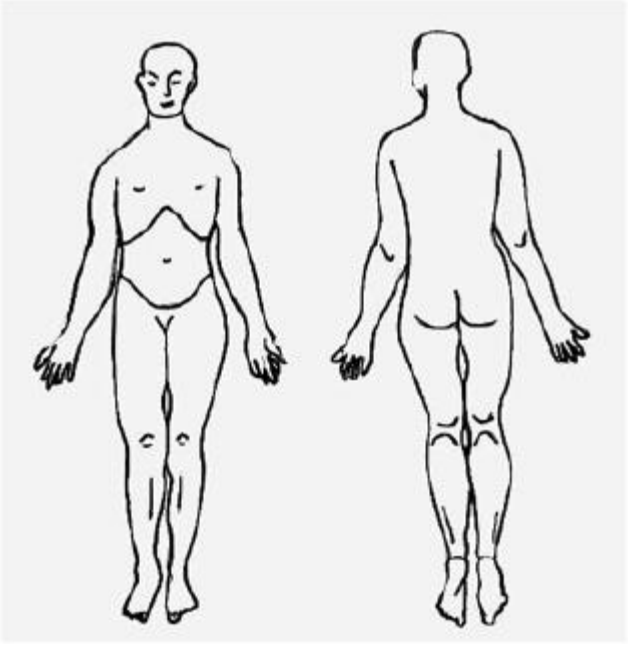
Patient or Guardian Signature:	*Date:*

Patient Name _____ Date: _____

You Turn Physical Therapy

Physical Therapy Pre-Exam Questionnaire

Please indicate the location of your symptoms on the body diagram below:



Briefly describe your symptoms:

□ Aching □ Constant
□ Sharp/Stabbing □ Intermittent
□ Numbness □ Burning
□ Tingling □ Other _____

On the scale below, circle your WORST pain the last couple of days

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your CURRENT level of pain:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your LOWEST LEVEL evel of pain:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

What caused your pain/or problem? _____

Approximately when did it start? ____/____/_____

Is it getting worse, better, or staying the same? _____

Have you ever had this pain/problem before? (Circle) YES NO

Are any of your usual everyday activities affected? YES NO
If yes, describe how:

List all past surgeries with dates:

List all medical conditions you have (or were told you have):

*** Please provide a list of all your current medications. (A photocopy of a printed list is acceptable).

_____ _____
Patient Signature Date

Cancellation and No-Show Policy

The following is our policy regarding cancellations and no-shows. We take this subject seriously, because it can make the difference in whether you succeed in your treatment or not. Cancellations, along with no-shows, also decrease our ability to accommodate the scheduling needs of other patients. Your full cooperation is required with the following policy:

- **Cancellations: We require 24 hours notice in the event of a cancellation.** It is your responsibility, when you call in, to have an alternative time in mind that will ensure you receive the prescribed number of treatments that week. If you cancel less than 24 hours in advance, you will be charged our cancellation/no-show rate of $75. If you have more than 2 cancellations within your course of treatment, your physician WILL be notified and you may be discharged from therapy.
- **No Shows:** It is important to be on time to your scheduled appointments. Please call us if you are running late for your appointment so we may plan accordingly. If you are late for your appointment, this will cut into your treatment time which may prevent an effective session from occurring. Again, you will be charged our cancellation/no-show rate of $75 if you do not show for you appointment.
- Please be advised that if you are being charged for the cancellation or no-show, that your insurance will not pay for that fee. You will be billed personally for that amount. You will need to pay that fee before or at your next appointment to be seen again for treatment.
- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments must be forwarded to your Case Manager and Primary Physician and could jeopardize your claim.
- Ensure that you have your preferred means of contact listed so we can provide you with an appointment reminder the day before your session. It is your responsibility to verify the correct appointment time when you get the reminder.
- When you do not show, as scheduled, or use appropriate cancellation procedures for your session, THREE people are hurt:

    - YOU - because you do not get the treatment you need.
    - THE THERAPIST - because they now have a vacant time that was reserved for you personally.
    - ANOTHER PATIENT - because they could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. WE ARE looking forward to working with you.

I acknowledge and understand the above:

_____ _____

Patient/Guardian/Responsible Party Signature Date