Center for Orthopedic and Lymphatic Physical Therapy

PATIENT INFORMATION *Please print clearly* Date____/_____/______

Patient Name____ Sex ☐ Male ☐ Female
Last *First* *M.I.*

Address____
Street *City* *State* *Zip.*

Parent or Guardian(if patient is a minor)____

Is patient employed ☐ Yes ☐ No ☐ Student Occupation ___________________________________

Employer or School____________________________ Home phone ( )________-_______________

Work phone ( )________-________________ Date of birth __________/__________/__________
If minor, parents work #

SS#_________-_________-________________ Marital status: ☐ Married ☐ Single ☐ Other

Refferring Dr.____
Name *Address* *Phone.*

Primary care Dr.____

Emergency Contact (not living with patient):____

Relationship____ Phone ( )________-_______________

Race/Ethnicity: ☐ African-American ☐ Caucasian ☐ Native American/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander
(*This information is strictly voluntary and will be kept confidential*)

INSURANCE INFORMATION *In order to bill your insurance(s), we must have a copy of your insurance card(s)*

Primary Insurance Co.________________________________

Policy/ID #____

Group #____

Is patient the subscriber: ☐ Yes ☐ No If no, then fill in below:

Subscriber's Name:____________________________________

Subscriber date of birth _________/_________/____________

Subscriber's employer__________________________________

Relationship to patient_________________________________

Secondary Insurance Co.________________________________

Policy/ID #____

Group #____

Is patient the subscriber: ☐ Yes ☐ No If no, then fill in below:

Subscriber's Name:____________________________________

Subscriber date of birth _________/_________/____________

Subscriber's employer__________________________________

Relationship to patient_________________________________

INJURY INFORMATION

Condition is related to: ☐ Work ☐ Auto ☐ Home ☐ Sports ☐ Other ☐ None

Date of injury/ onset of condition_______/__________/____________

Body side: ☐ Right ☐ Left ☐ Both Body part affected ____

VOCATIONAL REHAB COUNSELOR OR CLAIMS MANAGER *Worker's comp only*

Name____ Phone ( )________-______________

Address____
Street *City* *State* *Zip.*

CENTER FOR ORTHOPEDIC AND
LYMPHATIC PHYSICAL THERAPY ("COLPT")
463 Tremont Street W, Suite 100
Port Orchard, WA 98366
Telephone: 360-874-0745

Consent for Treatment: I hereby consent to COLPT making diagnostic records before, during and following the physical therapy treatment and providing physical therapy treatment prescribed by a physical therapist of COLPT for the Patient. I fully understand all of the risks associated with the treatment.

Appointments/Cancellations: If I must break my appointment due to illness, accident, etc., I will inform COLPT of my cancellation at least 24 hours prior to the scheduled appointment and another appointment will be reserved for me. Failure to call and inform COLPT may delay physical therapy progress since time may be lost in the reschedule process. Late arrival for appointments may necessitate possible appointment reschedule. If I fail to show for two (2) scheduled appointments or cancel several appointments, COLPT will discontinue my physical therapy treatment, and my physician will be notified.

Financial Agreement: I agree to pay all fees and charges for the physical therapy treatment. I agree to pay all charges for me and members of my family set forth in statements within fifteen (15) days of the billing date, unless written credit arrangements are agreed upon. Charges set forth in statements are agreed to be correct and reasonable, unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance due for physical therapy treatment rendered to me or my family, I agree to pay reasonable attorney's fees and any other such costs as the court determines reasonable and proper. Venue and jurisdiction shall be proper in Kitsap County, Washington. Any statement which has not been paid in full 30 days after the billing date, I will pay a $5.00 service charge or 1½% for balances over $350.00, for each monthly billing period, until the statement is paid in full.

I agree that payments for physical therapy treatment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. I agree that all monies I receive from any insurance company(ies) or other source(s) for physical therapy services rendered at COLPT shall be paid immediately to COLPT and applied to any unpaid balance owed to COLPT. I assign all of the insurance payments regarding my/Patient's physical therapy treatment to COLPT; however, COLPT is not responsible for the collection of said insurance payments. Should a physical therapy service be deemed not covered by the insurance company, I agree to pay in full for the services rendered. In the event that I receive a check from the insurance company applicable to the payment of physical therapy services, I will endorse the check and forward it to COLPT to insure proper credit to my account. I agree that if my account has an unpaid balance for services rendered at the time of settlement or judgment for any claim I have against a third person for injury necessitating the treatment received, I will immediately pay the entire balance owing to COLPT from said settlement or judgment. I authorize and consent to the release by COLPT of any information with regard to my physical therapy treatment to insurance company(ies) or to any other source that is or may be responsible for payment of the physical therapy services rendered by COLPT. I understand that COLPT will bill my insurance company for me. COLPT does not accept responsibility for collecting an insurance claim or for negotiating disputed claims. I am responsible for full payment of my account within 30 days. I understand that insurance reimbursement is a contract between me and my insurance company.

Acknowledgement: I hereby acknowledge that I fully understand the treatment considerations and risks of physical therapy treatment. I also understand that there may be other problems that occur less frequently than those presented, and that actual results may differ from the anticipated results. I also acknowledge that I have discussed this form with COLPT and have been given the opportunity to ask any questions. I have been given a signed copy of this form.

Signature:____ **Date:**_____/______/______

Print Name: ____

Copy of signed form given to Patient _________ __________

staff initial **date**

CENTER FOR ORTHOPEDIC AND
LYMPHATIC PHYSICAL THERAPY (“COLPT”)
463 Tremont Street W, Suite 100
Port Orchard, WA 98366
Telephone: 360-874-0745

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT INFORMATION PURSUANT TO HIPAA

I specifically waive any “minimally necessary” limitations of HIPAA and authorize COLPT to provide protected information regarding my health care and treatment, including my records, to other health care providers, insurance companies, governmental agencies, attorneys and third parties without requiring any additional authorization. This release and authorization shall apply to all of my health care information and records of any nature.

General Medical Information To Be Disclosed:

☐ Medical Records from (insert date)__________to (insert date)_____________

☐ Entire medical record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

☐ Other ____

____________ ______________________________________
Date **Signature**

Release Requiring Specific Consent:

Unless specifically excluded, my initials and signature below authorizes the release of specially protected health care information relating to testing, diagnosis or treatment for:
[check box to EXCLUDE from authorization]

☐ HIV/AIDS
☐ Sexually Transmitted Diseases
☐ Reproductive Care (Minors Only)
☐ Mental Health
☐ Alcohol/Drug Abuse

____________ ______________________________________
Date **Signature**

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT INFORMATION PURSUANT TO HIPAA

Period of Information to be disclosed: **Patient name:_______________________________**

____ All information, unlimited by time.
____ All records from ______________ to present.

Purpose of Disclosure: ☐ At request of Individual ☐ Legal ☐ Insurance
☐ Concurrent Care ☐ Other:________________

Expiration Date: This authorization is valid for 5 years from the date signed.

My Rights:

I may revoke this authorization at any time by writing to the health care provider above. I understand that once the health information I have authorized to be disclosed reaches the recipient, that person or organization may re-disclose it, at which time it may no longer be subject to HIPAA protection and other Privacy laws. I understand that once released, COLPT has o responsibility for any further release by the individual receiving the information. I have a right to request and receive a copy of the Notice of Privacy Practices.

____ I would like COLPT to leave me messages of a non-sensitive nature that
may contain protected health care information on my voice mail, answering machine or with a family member, **OR**

_____ I would like COLPT to leave me messages of a non-sensitive nature that
may contain protected health care information on my voice mail, answering machine or with a family member **only at the following designated telephone number:** ___________________________, **OR**

_____ I do not wish to have COLPT leave me messages containing protected
health care information

Signature:__________________________________ **Date:_______________**

Print Name: ________________________________

Date of Birth:_________________ **Social Security No. ______________________**

Day Time Telephone Number: _________________________

Copy of signed form given to patient _________ __________

staff initial **date**

Center for Orthopedic and Lymphatic Physical Therapy

Patient Health History

Name____ Occupation__________________________

____

Hobbies, recreational activities, sports

Physical Activities at work (circle all that apply)

Sitting Heavy lifting Repetitive lifting Computer use Driving Standing Walking

Other____

How is your general health? (circle one)

Excellent Good Average Fair Poor

Since the onset of your current symptoms have you had (circle all that apply)

Any difficulties with control of bowel or bladder function
Any numbness in the genital or anal area
Any dizziness or fainting attacks
Unexplained weight loss
Malaise
Fever/chills
Numbness
Weakness
Night pains/sweats
Problems with vision/hearing

Which of the following conditions have you ever been diagnosed as having? (circle all that apply)

Cancer	Depression	Heart problems
Hepatitis	High blood pressure	Tuberculosis
Asthma	Stroke	Emphysema
Kidney disease	Diabetes	Anemia
Thyroid problems	Epilepsy	Chemical dependency
Allergies	HIV/Aids	Anorexia/Bulimia
Multiple Sclerosis	Rheumatoid Arthritis	

Please list any surgeries or other conditions for which you have been hospitalized and approximate dates.

Date **Surgery** **Reason for surgery**

____

____

____

Please describe any injuries for which you have been treated and approximate dates.

Date **Injury**

____

____

____

____

Patient Health History Name____

Please list all the medications you are presently taking.

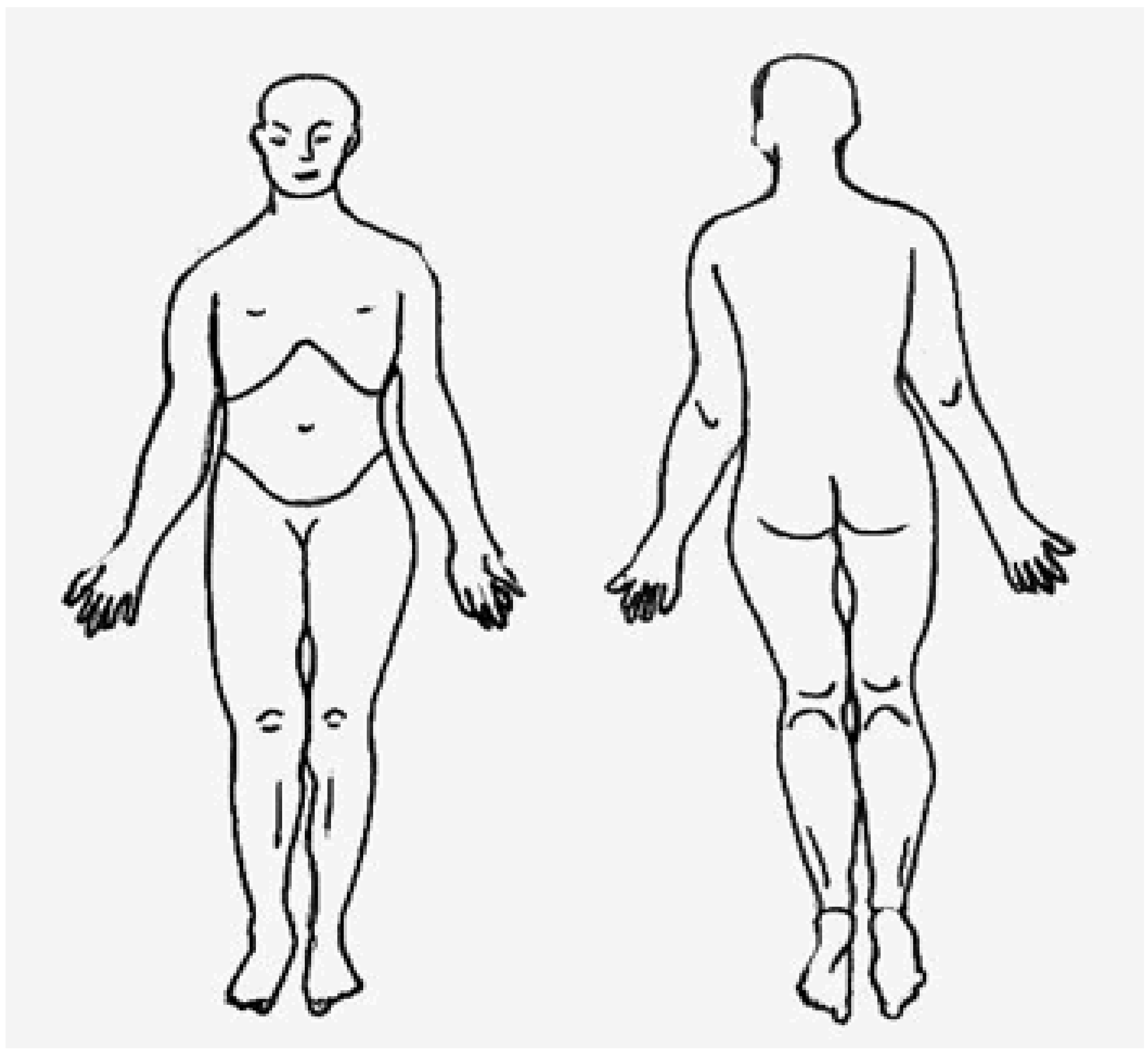
____

____

____

____

Please use the following body diagram to illustrate your areas of pain and abnormal sensation.



Pain Rating **0**____**10**

No pain **Excruciating**

Medical Appointment Cancellation Policy

Dear Patient,

Thank you for trusting your physical therapy care to the Center for Orthopedic and Lymphatic Physical Therapy (COLPT). We strive to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, COLPT uses an appointment system that sets aside ample time for 1:1 patient care treatments with your physical therapy provider.

If you do not show up for an appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient. With that in mind, a Medical Appointment Cancellation Policy has been put into place.

Our Policy is as follows:

1. We require that you give our office a 24-hours notice in the event that you need to cancel or reschedule your appointment. This will make the appointment time available to someone else. Our number is (360) 874-0745
2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a " late cancel/no show" appointment and a $50.00 fee will be assessed to you. Insurance does not pay for "late cancel/no show" appointments.
3. If you have 2 "late cancel/no show" appointments, you will be removed from the schedule and be seen on a same day call in basis depending on availability.
4. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.
5. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact Jerry Mercogliano at (253)549-3605 and he will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

____________________________ ________________________
Signature (Parent/ Legal Guardian) Relationship to patient

____________________________ ________________________
Printed Name Date

Center for Orthopedic Lymphatic Physical Therapy - Patient Medication List

Name: ______________________________ Date: ______________

Medication	Dosage	Frequency	Taken How	Rx	Reason	Doctor
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		
				Y N		