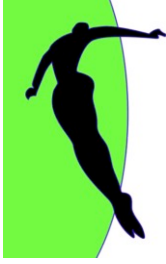


BIOJUNCTION
Sports Therapy™

Dear New Patient,

Thank you for choosing Biojunction Sports Therapy. We look forward to meeting you!

Enclosed you will find some information that will help you to get to know us and allow us to know more about you and the reason that you are visiting our clinic. It is helpful if these forms are fully completed prior to the start of your first appointment.

Please bring to the following to your first appointment:

- All completed registration and medical history forms.
- Your doctor's written prescription, especially if required by your insurance.
- Your insurance card and photo ID so that we may photocopy the necessary information.
- Comfortable clothing, preferably that will allow easy access to the body part being treated.

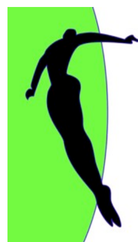
If you are being evaluated for orthotics, please also bring:

- A selection of the shoes you wear daily and/or are active in (sport shoes, work shoes, etc.).
- A pair of shorts or pants which can be rolled above the knee.

Please plan to spend 45 to 60 minutes for your initial evaluation. Should you have any questions regarding your appointment, feel free to call our office at (206) 938-0860.

Thank you!

3727 California Ave SW, Suite 1-A • Seattle, WA 98116 • Phone: 206.938.0860 • Fax: 206.938.0866
4005 Wallingford Ave N • Seattle, WA 98103 • Phone: 206.829.8269 • Fax: 206.829.8594
Email: info@biojunction.com • Website: www.biojunction.com



PATIENT & INSURANCE INFORMATION

Patient Information:

First Name________________ Middle I.________ Last Name ________________

If patient is a minor: Parent(s) name(s) ________________

Address________________ Apt. ________________

City________________ State________ Zip________

SSN ______-______-________ Gender________ Birthdate________________

E-mail (for appointment reminders) ________________

Home Ph________________ Work Ph________________ Cell Ph ________________

Preferred number Home________________ Work________________ Cell ________________

Appointment Reminder Preference E-mail ________________ Phone call ________

Emergency contact: Name________________ Phone ________________

Referring Doctor:________________ Phone ________________

Primary Doctor:________________ Phone ________________

Who may we thank for referring you? Physician/health care provider Internet/Social Media Neighborhood

Friend / family ________________ Other ________________

Insurance Information: *Complete this section only if you are unable to provide a copy of your insurance card.

Primary Insurance: *(Please let us know if you are covered by more than one insurance company.)*

Insured's Name________________ Birthdate________________

Insurance Co.________________ Cust. Service Phone ________________

Member ID#________________ Group # ________________

Was your injury the result of a WORK or AUTO accident? If so, please provide insurance info above AND complete this section:

Claim #________________ Date of Injury________________

Claims Manager________________ Claims Mgr phone ________________

Insurance Carrier________________ Claims Address ________________

Billing Information: Bill to patient address above ____ OR Bill to responsible party below ____

Name________________ Phone ________________

Address ________________

City________________ State________ Zip________

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION:

I understand, as the patient and/or above-mentioned responsible party, that I am fully responsible for payment of all charges incurred. This includes any deductibles, non-covered services, or non-authorized services. I assign all medical payment to Biojunction Sports Therapy.

I hereby authorize the release of any medical information necessary to secure payment for services rendered.

Patient Signature________________ Date:________________

(Parent or guardian, if patient is minor)

Biojunction Sports Therapy (West Seattle) • 3727 California Ave SW, Suite 1-A • Seattle, WA 98116
Phone: 206.938.0860 • Fax: 206.938.0866
Biojunction Sports Therapy (Wallingford) • 4005 Wallingford Ave N • Seattle, WA 98103
Phone: 206.829.8269 • Fax: 206.829.8594

Patient Name:________________________

CONFIDENTIAL
MEDICAL INFORMATION

1. What are we seeing you for? ____

____

2. Describe how and when your symptoms began *(Give specific date, if applicable)*: ______________________________

____

3. Overall, are your symptoms: (circle one) improving getting worse unchanged

4. On a scale of 0-10, with 0 being "No pain at all" and 10 being "Worst pain imaginable", for the last week please rate your level of discomfort: At **WORST**________/ 10; At **BEST**_________/ 10; What is it **CURRENTLY**:_________/ 10

5. Have you had similar symptoms in the past? *(if so, when)*____

6. Describe your symptoms: (circle all that apply) sharp dull numbness/tingling throbbing shooting aching burning other____

7. What aggravates your symptoms? ____

8. What eases your symptoms?____

9. Have you had any special tests regarding your symptoms (MRI, X-Ray, CT Scan, Ultrasound, EMG, bone scan)? Y N

   If yes, results? ____

10. Since your symptoms began, have you had any of the following: (circle all that apply)

Bowel or bladder issues	Weakness	Dizziness or fainting	Fever/chills/sweats
Significant weight change	Hearing or vision problems	Numbness or tingling	Difficulty swallowing
Pain at night	Numbness in the genital area	Nausea/vomiting	NONE

11. Please list your: Height ___________ Weight ___________

12. Allergies ____

13. Current medications ____

13. Major surgeries/injuries since birth ____

____

14. Are you currently being treated by:

Another physical therapist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Chiropractor	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Massage Therapist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Acupuncturist	Yes _____	No _____	Or within the last 12 months	Yes _____	No _____
Other __________________	Yes_____	No_____	Or within the last 12 months	Yes_____	No_____

15. Are you currently pregnant? Yes___ No__

16. Do you smoke? Yes___ No___

17. Do you drink alcohol? Yes___ No___ How many drinks/week?_________

18. Do you currently have or have you had a history of the following? (circle all that apply)

Alcoholism	DVT/ Blood clot	Multiple Sclerosis
Anemia	Emphysema	Osteoporosis/Osteopenia
Anxiety	Falls/Loss of balance	Pacemaker
Arthritis	Fibromyalgia	Parkinson's Disease
Artificial joints	Fractures	Pulmonary Embolism
Asthma	GERD	Rheumatoid Arthritis
Atrial Fib	Headaches/Migraines	Sensitivity to heat or ice
Cancer	Heart Attack	Seizures
Chemical dependency	Heart Murmur	Shortness of breath
Congestive Heart Failure	Hepatitis	Sleep Disorder/Apnea
COPD	HIV/AIDS	Stress fracture
Coronary Artery Disease	High Cholesterol	Stroke/TIA
Crohn's Disease/ Ulcerative Colitis	High Blood Pressure	Substance Abuse
Depression	Joint replacement	Thyroid disease
Diabetes	Kidney Disease	Ulcers
Dizziness/Vertigo	Loss of menses	Other ____________________________
	Late onset of menses	

19. Exercise or activities that you enjoy: ____

20. Occupation: ____

21. Are you currently able to perform all your regular work/home duties? Yes___ No___

The above information is true and accurate to the best of my knowledge.

Patient Signature:____ Date:______________________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Biojunction Sports Therapy to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of the presenting physical condition(s) to the patient named below.

Patient Name:____

Patient Signature: ____ Date: ____________________

(Parent or guardian, if patient is minor)

FINANCIAL POLICY STATEMENT

Insurance Billing –

- As a courtesy to our patients, we will bill your insurance(s) based on the information you provide.
- All co-pays are due at time of service. Other costs (e.g., deductible, co-insurance) will be billed to the patient or responsible party after the insurance has processed your claims.
- Please be advised that it is your responsibility to know the limitations and/or restrictions of your insurance company/plan regarding physical therapy treatment and orthotics. We recommend that you contact your insurance company prior to your first appointment to verify your coverage for outpatient physical therapy, and to determine if your plan requires a prescription or referral from your physician.

Please understand that you are financially responsible for any deductibles, co-pays, and non-covered, or non-authorized services.

Interest Charge/collections fees

- Any balance remaining after 60 days from the billing date will incur an interest charge at the rate of 1% per month, 12% annually.
- If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

For L&I Claims:

- Be advised that you may be responsible for your charges if your Workers' Compensation claim is closed or denied.
- If you miss two (2) scheduled appointments without 24 hours notification, your claims manager will be contacted and you may be held responsible for the No-Show fee(s).

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name:____

Patient Signature:____ Date:______________________

(*Parent or guardian, if patient is minor)*

CANCELLATION AND NO-SHOW POLICY

We ask that you please give one full business day's (minimum 24 hours) notice in advance to cancel an appointment. Any no-show or late cancellation within 24 hours of the scheduled appointment time will result in a cancellation charge of **$50.00.** This charge cannot be billed to your insurance.

Physical therapy is most effective when the patient is an active participant in their home exercise program and when they attend all appointments prescribed by their therapist. Therefore, it is very important that you attend all scheduled appointments.

If a cancellation is unavoidable, we ask that you give as much notice as possible so that we may offer the appointment to another patient. If you arrive more than 15 minutes past your scheduled appointment time, we may ask you to reschedule that appointment or may offer you a shorter treatment time based on what our schedule allows.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name:____

Patient Signature:____ Date:_______________________

(*Parent or guardian, if patient is minor)*

NOTICE OF PRIVACY PRACTICES (Required by law)

Biojunction Sports Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20,2000.

- We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

- Our clinical and front office staffs use patient information to ensure quality care and appropriate billing for services.

- You may correct, amend, access, and request a copy of your medical records by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

- We protect all patient information within the guidelines provided by federal, state, and local government.

- If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Billing Manager at 206-938-0860.

- Biojunction Sports Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations, and guidelines.

- It is okay to call and leave a detailed message regarding medical appointments.
  Yes / No initial: _________

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.

Patient Name:____

Patient Signature:____ Date:_______________________

(*Parent or guardian, if patient is minor)*