BONNEY LAKE
Physical Therapy & Hand Rehab, PLLC

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Patient Consent Form for: Patient's Name: _____

Welcome to Bonney Lake Physical Therapy and Hand Rehab. We are committed to providing comprehensive rehabilitation services that restore physical function and improve quality of life. Therapy has been ordered for the patient named above. In order to initiate services, we need your signature on this authorization form. Please read and sign where indicated below.

Please ask if you would like a copy of this form

Authorization for treatment and release of information:

1) I consent for this provider to render the treatment set forth above as ordered by my physician.
2) I give authorization for therapy to be provided in areas not totally isolated from other patients and personnel.
3) I understand that I am free to choose my therapy provider independent of insurance plans, referring physicians and have elected to choose Bonney Lake physical Therapy & Hand Rehab as my provider.
4) This authorization, or photocopy of same, authorizes the release of medical information to: 1) My referring physician and claims managers for effective communication. 2) My insurance company including medical insurance, auto & workers compensation insurance necessary to process claims.
5) For any circumstance other than that listed in number 4 above, a separate signed authorization will be required to release any information. (fees may apply)

Reimbursement Coverage:

1) I request and authorize the patient's insurance coverage to make payments of authorized benefits on the patient's behalf directly to this provider.
2) I understand that I am ultimately responsible to pay for services provided to the patient including any of the following:
    a. a) Any applicable deductibles or co-payments.
    b. b) Any non-insured or non-covered services authorized above.
    c. c) Any charges in excess of payment limitations imposed by third party payers.
3) I understand that missed appointments without cancellations within 24 hours will be charged $35.
4) I understand that any amount not paid within 60 days along with any other attorney or collections fees associated with the account will be subject to a monthly billing service charge of 1%.

I have read and understand the above.

Signature of patient / representative: _____ Date _____

Consent for Photographs:

I hereby authorize Bonney Lake PT & Hand Rehab to take photographs of me for the use in treatment to monitor progress with my condition, to assess splinting and taping needs and for the use for educational purposes. I understand that none of my personal information about me will be disclosed for the privacy laws that are in place. I understand by giving my permission for the use of photographs will in no way hinder the quality of care provided. I hereby release Bonney Lake Physical Therapy & Hand Rehab from any liability associated with the use of the photographs provided and described above.

Signature of patient / representative: _____ Date _____

Notice of Privacy Practices:

I acknowledge that I have read/reviewed my rights regarding medical information pertaining to my treatment at Bonney Lake Physical Therapy and Hand Rehab. I understand that I can request a hard copy of my rights at any time.

Signature of patient / representative: _____ Date _____

If someone other than the patient has signed, please state your name and relationship to the patient:

Name: _____ Relationship to patient: _____

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Patient Information Form

Please Print Clearly

Patient's Last Name: _____ Eval Date: _____

First Name, M.I: _____ Onset Date: _____

Street Address: _____ Social Security #:_____

City, State, Zip: _____ Marital Status: M __ S __ W __ D __

Home Ph: _____ Cell Ph: _____ Preferred contact? Home / Cell Is Patient a Minor Yes___No__

E-mail address: _____ Birthdate ___/____/____ Sex: M_____ F ____

Guardian/Power of Attorney_____Relation_____

Emergency contact name & phone: _____ Relation _____

Address:_____

Referring Doctor & NPI: _____ Phone: _____

Address: _____ FAX: _____

Primary Coverage Carrier (copy card) _____ Phone: _____

Address: _____

Subscriber: _____ Relation to Insured: Self___ Spouse ___ Child ___ Other ____

ID or HIC #: _____ Group #: _____ Plan #: _____

Prior Authorization ID #: _____ Contact Person: _____

Secondary Coverage Carrier (copy card) _____ Phone: _____

Address: _____

Subscriber: _____ Relation to Insured: Self___ Spouse ___ Child ___ Other ____

ID or HIC #: _____ Group #: _____ Plan #: _____

Prior Authorization ID #: _____ Contact Person: _____

Lawyer _____ Phone: _____

Address: _____

Para Legal _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Voc. Rehab Counselor:_____Phone_____Fax_____

Medical Diagnosis Code: _____ Description:_____

Medical Diagnosis Code: _____ Description:_____

1st Treatment Dx Code: _____ Description:_____

2nd Treatment Dx Code: _____ Description:_____

Was this as a result of an accident?_____Yes_____No Auto___Yes___No At Home___Yes___NO

At work?___Yes___No Is someone Else responsible for your injuries?___Yes___NO

Brief Medical History

BONNEY LAKE
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Name: ____

Birthdate:____________________________ Age: ______________ Date of Injury / Onset: __________________________

Hand Dominance: Right / Left Sex: F / M Marital Status: M__ S__ W__ D__ O__

Employed: (circle one) Full Time Part Time Retired Disabled Student Unemployed

If employed; Title & Duties:____

What activities do you have difficulty doing due to your injury / condition? ____

____

Previous treatment(s) for injury: Y / N (If yes, please explain)____

Goals for Therapy:____

Pain level scale "0-10": 0 = no pain / 10 = hospital trip: Resting: _________ Activity: _________ Sleeping: _________

Please indicate any conditions you have now or in the past:

Diabetes	Yes / No
High Blood Pressure	Yes / No
Heart Disease / Attack	Yes / No
Pacemaker	Yes / No
TMJ Disorders	Yes / No
Headaches	Yes / No
Kidney Disorders	Yes / No
Nervous Disorders	Yes / No
Circulatory Disorders	Yes / No
Pulmonary Disorders	Yes / No
Asthma	Yes / No
Depression / Emotional	Yes / No
CVA / Stroke	Yes / No
Head Injury	Yes / No

Do you smoke?	Yes / No
Sensitivity Ice / Heat	Yes / No
Orthopedic injuries/concerns (back/neck)	Yes / No
Orthopedic injuries/concerns (extremities)	Yes / No
Orthopedic Implants or Artificial Joints	Yes / No
Previous Surgery	Yes / No
Hernia	Yes / No
Pregnant	Yes / No
Cancer: Type _____________________	Yes / No
Dizziness, Blurred Vision, Seizures	Yes / No
Previous Vehicle Accident	Yes / No
Forgetfulness	Yes / No
Arthritis	Yes / No
Other Illness	Yes / No

If yes on any of the above, please explain and give approximate dates. ____

____

____

Allergies: ____

Do you have sensitivity to latex? Yes _______ No _______

Current medications: Yes / No If yes, please list and for which condition: ____

____

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The undersigned acknowledges and agrees that the above information is true and correct.

____ _____________________________

Signature Date

____

Printed Name