Pre-Exam Form

Name: _____ Age:_____ Gender: F M Occupation_____ Are you working now? ☐ Yes ☐ No

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Where is your pain/problem? _____
2. What caused your pain/or problem? _____
3. Approximately when did it start? ___/___/20____
4. **List ONE ACTIVITY** you are unable to do, that you absolutely want to be able to do again:

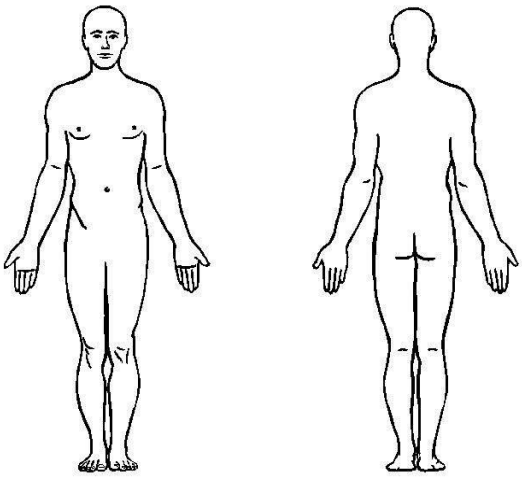
_____

5. Have you ever had this pain or similar pain /problem before? ☐ Yes ☐ No If yes, when and describe
6. On the scale below circle your worst pain level in the past couple of days:

Mild *Moderate* *Severe*

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

7. **Draw** your pain in the diagram to the right; circle areas of numbness or tingling



8. List all past surgeries with dates: _____
9. List all medications you are taking _____
10. List all medical conditions you have (or were told you have)

_____

11. How optimistic are you that you'll get better? (circle one)

Not at all……Mildly Optimistic……Fairly……Very Optimistic……..Extremely

12. In your understanding, what do you think will make you better? _____

_____

13. What are some potential obstacles to you getting better? _____

_

_____

14. Over the next 30-days how many hours per week will you commit to getting better _____
15. What are you expecting from your Physical Therapy program? _____

_____

16. My Primary care Physician is_____phone_____

I understand that my **candidacy** for a **rehabilitation program will be dependent upon my ability and willingness to improve.** I have answered the questions above **honestly and accurately** to the best of my ability. The doctor/therapist will determine whether or not I am a **viable candidate** for a rehabilitation program and that my activation into their system is not guaranteed.

Signature: _____ Date: _____

INTAKE FORM

Patient Full Name_____ Date of Birth _____ Age:_____ Sex: M F

Address: _____ City/State/Zip:_____

Cell Phone: _____ Email Address:_____

Emergency Contact Person & Phone:_____

Primary Physician:_____ City/State:_____ Phone #:_____

If patient is a MINOR, parent/guardian's name and signature here: _____

FITNESS Goals: ❑ Lose Weight ❑ Body Toning ❑ Other: _____

STRESS Level : 1 low----2----3----4----5 high What's the main cause? _____

NUTRITION: What is your level of nutrition knowledge? ❑ None ❑ A little ❑ Medium ❑ A Lot

SUPPORT STRUCTURE: Who do you have nearby that is close to you? ❑ Family ❑ Friend(s) ❑ None ❑ Other: _____

Name something that is really important to you (or really enjoy doing)? _____

PERSONALITY TYPE: ❑ Social ❑ Emotional ❑ Intellectual ❑ Physical

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How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Facebook ❑ Advertisement ❑ Other: _____

IMPORTANT RULES & POLICIES

1. Late Policy: If I'm late more than 10-minutes to my appointment, I may be rescheduled or asked to wait for the next available open time slot.
2. **48-Hour advance notice** is required for changes to my appointment otherwise a $**45 fee** may apply.
3. *Not showing up for an appointment without notice (or less than 48-hours in advance) will result in a $**90 fee** added to my account.*
4. Co-pays and/or deductibles are due prior to treatment starts.
5. Cell phones must be shut OFF or silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason you are NOT satisfied with the care received, please call our administrator at 206-747-9247

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Lilly Physical Therapy, LLC and the physical/occupational therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Lilly Physical Therapy, LLC, and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Lilly Physical Therapy, LLC, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Lilly Physical Therapy, LLC and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Lilly Physical Therapy, LLC.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE Lilly Physical Therapy, LLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: _____ Signature_____ Date:_____

INSURANCE ASSIGNMENT OF BENEFITS

Patient Full Name_____ ❑ Single ❑ Married

Referring Physician:_____ PH_____ FAX_____

Street Address_____ City/State:_____ Zip_____

Work status: ❑ Currently Employed ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T or ___F/T)

POLICY #1:

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Address (if different than patient):_____

Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:_____

Employer_____ PH_____ Claim#_____

Employer address._____

POLICY #2 (if applicable)

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Declaration to Insurance Company

I hereby instruct and direct _____ insurance company to pay by check made out to the "Healthcare Provider" named below and mailed to the address below. If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the "Healthcare Provider" for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Conditions Required in Order for "Healthcare Provider" to Accept This Assignment

If any boxes are left unchecked, clinic reserves the right to refuse this assignment and patient must pay out-of-pocket for services.

- ☐ A photocopy of this assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance claims.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.
- ☐ This is a direct assignment of my rights and benefits under this policy.

DATE: _____ Signature of Patient/Claimant _____

Signature of Policy Holder if not same as patient_____

Credit Card on File Program Agreement

In an effort to eliminate wasteful use of paper, postage, and staff time, and to provide convenience to our patients, we now offer a "Credit Card on File Program". This helps to secure payment for the portion of services that your insurance doesn't cover, but for which you are responsible.

Without this authorization, a billing fee of $35 will be added to your account for any balances that we must attempt to collect through the mailing of invoices and statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged each month that the bill remains unpaid.

Your credit card information is kept **confidential and secure** and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Outstanding Balance: If your insurance provider has paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, our office will notify you via email and/or mail. If the balance owed is not paid within 30 days, our office will charge the balance to your credit card. A copy of the charge will be emailed to you.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Credit Card Holder's Name: _____

Credit Card # _____ Exp Date: _____

Security Code: _____

This credit card on file is to be used for the following patient(s), please print name(s) below:

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Lilly Physical Therapy, LLC in writing and the account must be in good standing.

I authorize **Lilly Physical Therapy, LLC** to charge the portion of my bill that is my financial responsibility to the credit or debit card above.

Patient Name_____ Date_____

Patient Signature_____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

HIPAA Notice Acknowledgement

I have received and read the Notice of Privacy Practices for the office Lilly Physical Therapy and understand my rights contained in the notice.

Signature	Date
Printed Name	Print Name of Legal Guardian, if applicable