MUSCLE THERAPY NORTHWEST

♦ Manual Physical Therapy ♦ Aquatic Physical Therapy ♦ Massage Therapy ♦ Rehab Therapies ♦

21009-76th Ave. West Edmonds, WA 98026-7126
(425) 672-2910 ♦ Fax (425) 778-1872

WELCOME*!!*

You have chosen Muscle Therapy Northwest for your therapy needs because you want to improve or resolve your medical condition. Your participation in your treatment plan is essential.

If you feel your medical and/or treatment needs are not being met, bring it to the attention of the therapist and/or the Clinic Administrator, Pam Estrella.

ASK QUESTIONS. If you don't understand your treatment program or if you are experiencing increased pain or discomfort after treatments or any other issues or concerns you may have, PLEASE bring it to our attention. It is very important that you be involved in your care.

COMMUNICATION is the pathway of quality medical care. Muscle Therapy Northwest, Inc. continues to strive down that pathway--please join us!

Please take a few minutes to fill out these forms. We at Muscle Therapy Northwest feel that your documentation is very important in helping us to determine the best treatment program for your individual needs.

If these forms are not filled out, your appointment may be rescheduled.

Sincerely,

Pamela C. Estrella

Pamela C. Estrella
Clinic Administrator

MUSCLE THERAPY NORTHWEST

♦ Manual Physical Therapy ♦ Aquatic Physical Therapy ♦ Massage Therapy ♦ Rehab Therapies ♦

21009-76th Ave. West Edmonds, WA 98026-7126 (425) 672-2910 Fax (425) 778-1872

PATIENT INFORMATION			
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birthdate: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -	Spouse:	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:	☐ Insurance Plan ☐ Family ☐ Friend		
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**	
Primary Insurance: ☐ Regence ☐ Premera ☐ USFHP ☐ Aetna ☐ Cigna ☐ First Choice	
☐ Uniform Medical ☐ United Health Care ☐ Other:	
Subscriber's Name (If different):	Birthdate : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birthdate : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**			
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Muscle Therapy Northwest. I understand that I am financially responsible for any balance. I also authorize Muscle Therapy Northwest to release any information required to process my claims.

PATIENT GUARDIAN SIGNATURE DATE

Muscle Therapy Northwest, Inc.

CONTRACTURAL AGREEMENT I f you would like a copy for your records, please advise the front desk

I, the undersigned, fully understand and agree to the following terms and conditions:

As a *courtesy*, Muscle Therapy Northwest will do their very best to verify and obtain accurate benefit information from your insurance carrier. We highly encourage our patients to be involved in all aspects of their health care including contacting their insurance carrier to verify the information we have obtained is accurate, as the information reported to our office is not a guarantee from your insurance carrier regarding what your final benefits / payments will be. Ultimately the financial responsibility of your health care belongs to you, the patient; additionally, the insurance carrier has a fiduciary responsibility to you as the subscriber / customer allowing you more rights in managing a correction of misquoted benefits than we, as your provider of service, are allowed / granted. Any accident policies (such as Personal Injury Protection) are an arrangement between the patient and the insurance carrier. Muscle Therapy Northwest is not a party to that contract. Our office will prepare any necessary reports and forms for processing of insurance claims. The patient is responsible for providing current and accurate insurance coverage information. In the event you do not provide the current / accurate insurance coverage information, we reserve the right to charge a $20 administrative fee to rebill the corrected insurance plan. In the event of a disputed claim by your insurance company whereas a patient financial responsibility is being reported that is believed to be inaccurate, Muscle Therapy Northwest can offer assistance on your behalf, in resolving the billing / eligibility / "misquote of benefits" issues with your insurance company. If you should elect to utilize this service, there is a one time fee of $30 per occurrence. During the time period of working to resolve the disputed information with your health plan, monthly payments from you will be required on your unpaid account balance. Payment arrangements can be made; however, monthly rebilling fees will accrue to the unpaid account balance.

Based on an estimated average of our charges for a treatment session, your estimated cost will be based on the percentage apportioned to you by your insurance company (i.e., 10%=$12.00, 20%=$24.00, 30%=$36.00, etc.). Our fees are usual and customary for the area. Our fees range from $80.00-$250.00 per hour. Fees are determined by the modalities, procedures, activities provided. We have preferred provider contracts with most insurance plans in our area, it is their fee schedule and payment policies that will ultimately determine what your financial responsibility will be.

By signing below, you give this office limited power of attorney to endorse checks made out in your name from your insurance company or any other entity *for services provided by this clinic*, so that they may be credited to your account. I also hereby assign my insurance benefits to be paid directly to the health care provider.

In cases of financial hardship, each case will be handled on an individual basis according to our financial policies. This must be discussed with the Clinic Administrator at Muscle Therapy Northwest at the time of the initial visit. Communication is essential to keep your account with Muscle Therapy Northwest in good standing.

Returned checks will be subject to a $30.00 fee.

If your treatment at Muscle Therapy Northwest is elected to be suspended or terminated, all fees for professional services become immediately due and payable within thirty days. Unpaid balances after 30 days will be assessed a monthly re-billing fee of $25.00. Additionally, overdue accounts (sixty days or more) may be assessed interest at the rate of twelve percent (12%) APR. If your account is turned over to our collection agency or our attorney, you will be responsible for all fees related to their efforts in collecting on your unpaid account balance.

******Cancellation Policy****** If you are unable to keep your appointment, 24 hours in advance notice to our office is required to avoid the $30 cancellation / no-show fee. This fee cannot be billed to your insurance company, and you are solely responsible for its payment. If you miss three scheduled appointments without appropriate notification, Muscle Therapy Northwest reserves the right to terminate your privileges in continuing your care at this clinic.

I certify that the information provided herein is true and correct to the best of my knowledge. I fully understand and accept all the terms of this contract, and give my signature here as testimony to this full understanding and acceptance.

Signature: _____ Date_____

Printed Name:_____

Muscle Therapy Northwest, Inc.

PAST MEDICAL HISTORY FORM

Please check the appropriate area or list area next to description

GENERAL	YES	NO
Hypertension or Low Blood Pressure	☐	☐
Fatigue	☐	☐
Nervousness/Irritability/Depression	☐	☐
Heart Condition (Type)_____	☐	☐

AREAS OF PAIN	YES	NO
Neck/Head	☐	☐
Mid-Back /Scapulae	☐	☐
Low Back /Pelvis/Sciatica	☐	☐
Shoulders/Elbow/Wrist/ Hand/Finger	☐	☐
Hip/Upper leg/knee/lower leg/ankle/foot	☐	☐
Chest/Ribs/Breastbone	☐	☐

MUSCLE CONDITIONS	YES	NO
Muscle Spasms	☐	☐
Pins & Needles Sensation	☐	☐
Numbness	☐	☐
Pinched Nerve Where?_____	☐	☐
"Slipped Disc" Where?_____		
Loss of Balance/Difficulty Walking	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Severe Sprain/Strains	☐	☐
Dislocation/Fracture (Broken bones)	☐	☐
Tendonitis/Bursitis	☐	☐
Swollen joints	☐	☐

OTHER CONDITIONS	YES	NO
Fainting/Lightheadedness	☐	☐
Arthritis (Type)_____	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes/Hypoglycemia	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Cancer (Type) _____	☐	☐
Have you previously had treatment for the condition you are being seen for today?	☐	☐

Is there any other condition you would like us to be aware of?

_____

_____

_____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
☐ None	☐ Sitting	☐ Low	☐ Smoking	Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol	Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda	Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor			

What types of exercise do you perform? : _____

What things cause stress in your life? : _____

When did you first start experiencing the symptoms for why you are being seen today? _____

Are you taking any seizure medication? ☐ YES ☐ NO If yes list name:

Please list, or attach a list, of ALL medications you are currently taking including over the counter medications, herbals, etc. _____

_____

_____

List all surgeries in the past two years (including dates): _____

_____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

_____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

_____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

Signature Date

21009 76th Avenue West Edmonds, WA 98026 *PHONE (425) 672-2910* *FAX (425) 778-1872*

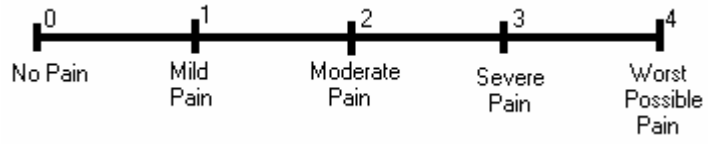
Muscle Therapy Northwest, Inc

Functional Rating Index

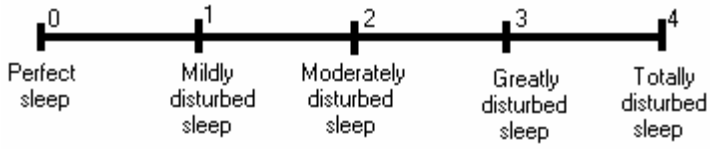
In order to properly assess your condition, we must understand how much your musculoskeletal problems have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition right now.

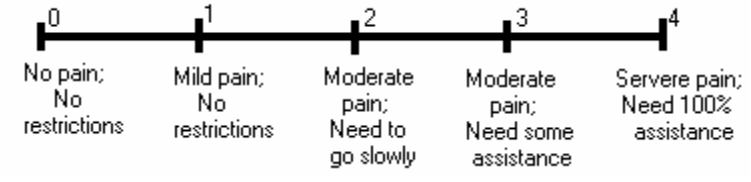
1.Pain Intensity



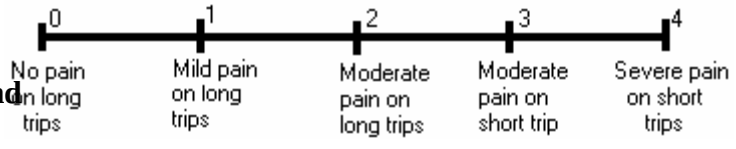
2.Sleeping



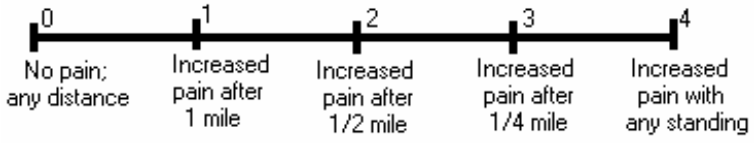
3.Personal Care (washing, dressing, etc.)



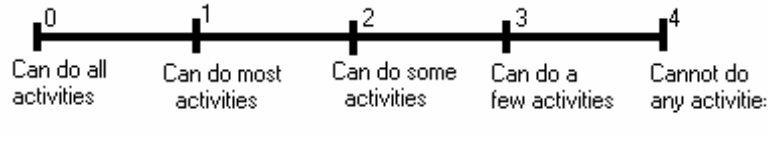
4.Sitting (driving, etc.)



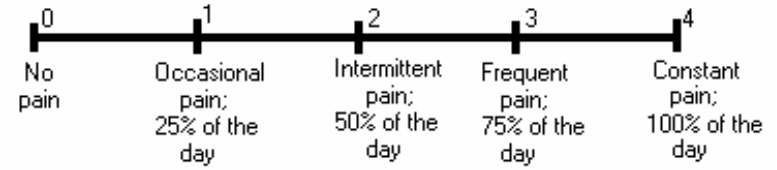
5.Walking



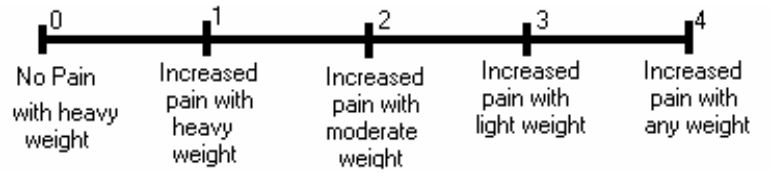
6. Recreation



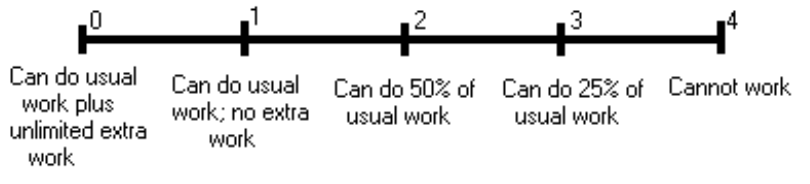
7. Frequency of Pain



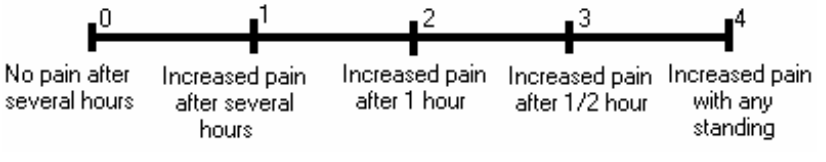
8. Lifting



9.Work



10.Standing



Patient's Signature **Date**

MUSCLE THERAPY NORTHWEST

Physical Therapy ♦Aquatic Physical Therapy ♦Massage Therapy ♦Aquatic Massage Therapy ♦ASTYM

21009 76th Avenue West, Suite B, Edmonds, WA 98026
(425) 672-2910 t Fax (425) 778-1872

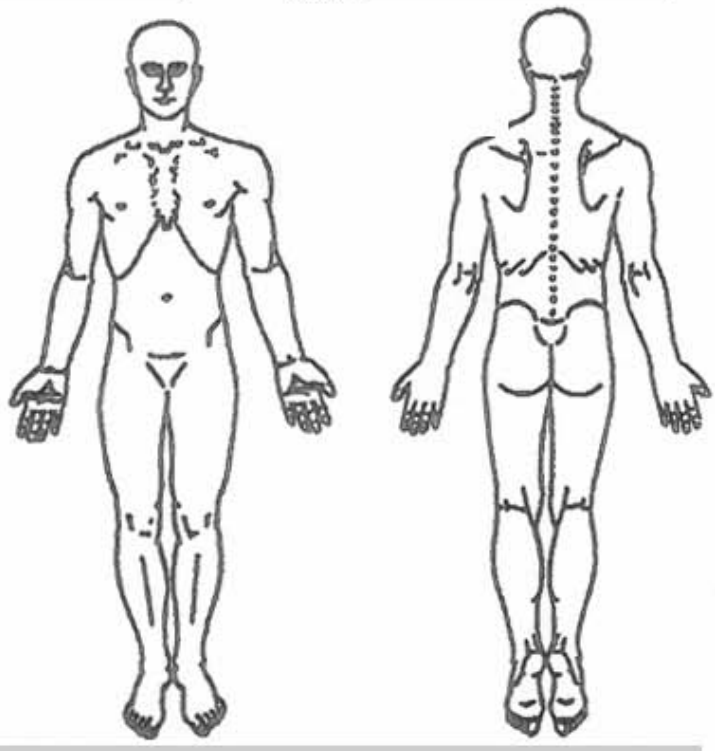
PAIN LOCATION AND RATING SCALE

Name: _____ **Date:** _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	O O O O
M	— —	O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / /	xxxx
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / /	xxx



PAIN INTENSITY RATING SCALE

My Chief Complaint is: _____
Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it

Patient Signature: _____ **Date:** _____

CANCELLATION AND NO-SHOW POLICY STATEMENT

We take cancellations and no-shows seriously at Muscle Therapy Northwest. We realize that sometimes you must cancel an appointment. However, the success of your physical therapy depends on maintaining your treatment plan as prescribed by your physician and established by your physical therapist. Your progress toward improved health can be thrown off course if you do not receive your treatments at the appropriate scheduled times.

We understand that either an increase or decrease in pain can seem like a reason not to come in. Sometimes when you feel worse you may think the treatment is not working, other times you are feeling better and may think you no longer are in need of more physical therapy. Your pain levels will most likely fluctuate over the course of treatments, before it is finally erased. This is normal. If you are in pain, come in and let us help you! If you're out of pain, now is the time progress to the next step by strengthening your injured area, make the correction to the underlying cause that brought you to our office in the first place, and allow our therapists to educate you regarding how to keep from re-injuring yourself in the future.

When you don't show up for an appointment three people are hurt:

1. You, because you will not get the treatment you need as prescribed by your physician and your physical therapist.
2. The physical therapist, which now has an unused hour in his or her schedule.
3. Another patient, who could have scheduled treatment in your reserved timeslot.

24-hour advance notice is required in the event of a cancellation. It is your responsibility to ensure that you arrive on time for all of your treatments as outlined and advised by your physical therapist.

Any notice of cancellation received less than 24 hours before the scheduled appointment time is a late cancellation. We have a **three late cancellations policy.** The first late cancellation will not result in a charge. However, your next late cancellation will result in a $30 fee, which you must pay before treatment continues. Upon the third late cancellation, your treatment program will be reviewed with the physical therapist and your physician, and subject to discharge and termination of care from the clinic.

No-shows can not be tolerated. If you do not show-up for an appointment we will contact you regarding the matter and a $30 no-show fee will be assessed to your account that must be paid before treatments continue. If we are not able to reach you or we do not hear from you within 24 hours of your first action of a no-show, your treatment program will be reviewed by the physical therapist and may be subject to termination of care and discharge from the clinic. A second no-show will result in immediate termination and discharge from the clinic.

We believe this policy is the best way to serve you. Please cooperate with us regarding cancellations.

_____ _ _____

Patient Signature Date

CANCELLATION OR NO-SHOW TRACKING FORM

Cancellations			No-Shows		
Date	**Patient Initials**	**Action**	**Date**	**Patient Initials**	**Action**
		Allowed			$30 fee
		$30 fee			Discharge
		Discharge	XXXXXXXX	XXXXXXX	XXXXXXXX