PHYSICAL THERAPY | HAND THERAPY
YOUR BEST SELF

South Sound Physical & Hand Therapy
An Affiliate of IRG Physical & Hand Therapy

PATIENT INTAKE FORM

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____ DOB ___/___/_____

Preferred Name _____ Preferred Pronouns _____ Gender *(on insurance policy)* ❑ Male ❑ Female

Address _____ Apt#_____ City _____ State _____ Zip _____

Cell Phone (_____) _____-_____ Home Phone (_____) _____-_____

May we leave a detailed voicemail/text message if we are unable to reach you in person? ❑ Yes ❑ No

Email Address _____ *(IRG will not share, sell or trade your information)*

I would like to receive appointment reminders via ❑ Email ❑ Text Message

Referring Provider _____ Office/Clinic _____ Last Visit ___/___/_____

Primary Care Provider _____ Office/Clinic _____ Last Visit ___/___/_____

Outside of a doctor referral, what made you choose IRG & Affiliates? *(select all that apply)* ❑ Doctor Referral Only

❑ Athletic Trainer/Coach ❑ Drive By ❑ Friend/Family Referral ❑ Insurance Company ❑ Radio/TV

❑ Community Event ❑ IRG Employee ❑ Health Club/Gym ❑ IRG Presentation ❑ Website/Google/Socials

In case of an emergency, please contact:

Name _____ Relationship_____ Phone (_____) _____-_____

INSURANCE INFORMATION *(estimate of benefits will be given at check in)*

Primary Insurance Company _____ Subscriber ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Subscriber Information *(if different than patient):* Name _____ DOB _____

Member ID *(including prefix)* _____ Group# _____

Secondary Insurance Company _____ Subscriber ❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

Subscriber Information *(if different than patient):* Name _____ DOB _____

Member ID *(including prefix)* _____ Group# _____

Tertiary Insurance Company: _____

Is your injury or condition work related or the result of a motor vehicle accident? ❑ Yes ❑ No

**if yes, completion of L&I/Workers Comp/MVA information form is required – regardless of claim status*

NOTICE OF PRIVACY PRACTICES

Please check one:

CLICK TO VIEW

❑ I acknowledge receipt of a copy of the Notice of Privacy Practices

❑ I have been offered a copy of the Notice of Privacy Practices, but I have chosen to decline a copy at this time

I authorize the following parties to receive information regarding my condition, treatment and/or billing information:

Name: _____ Relationship _____

Name: _____ Relationship _____

MINOR PATIENTS

I authorize examination and treatment by Integrated Rehabilitation Group (IRG) & Affiliates employees in the event a parent or guardian is not present: ❑ Yes ❑ No

Parent/guardian information completing and signing intake paperwork:

Name _____ Relationship_____ Phone (_____) _____-_____ DOB _____

CONSENT TO TREATMENT / ASSIGNMENT OF BENEFITS

By signing below I hereby consent to evaluation and treatment *(or evaluation and treatment of my dependent)* ***at Integrated Rehabilitation Group (IRG) & Affiliates. I authorize all available medical insurance benefits be directly assigned to Integrated Rehabilitation Group (IRG) & Affiliates for services rendered. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.***

Patient Signature: _____ Date:_____

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FINANCIAL POLICY

GENERAL FINANCIAL & CANCELLATION POLICY

As a courtesy, you will receive an estimate of benefits at check in. This is an estimate only and not a guarantee of payment. Our Billing Department is available to discuss any questions you may have regarding your insurance or account at 425-357-9380 or 1-877-228-9217 during the hours of 7:00 AM to 5:30 PM Monday through Friday.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract with your insurance company dictates the services that are covered, and the amount of payment for those services.

DOCTOR REFERRALS: You are responsible for obtaining the appropriate referral from your physician prior to you appointment if one is required by your insurance company.

PAYMENTS: Copays are due at the time of service. Any deductible or co-insurance that is patient responsibility will be billed to you after claims have processed from your insurance company. If an account becomes past due necessary action will be taken, up to and including, turning the account over to our attorney or collections service. If financial problems arise, please contact our Billing Department to discuss payment plan options.

CANCELLATION POLICY: In order to provide timely and consistent care for all patients, we require 24 hours notice for all appointment changes. Cancellations or no-shows throughout your care plan may result in a review of your case and could impact your ability to schedule future sessions. If multiple instances occur, we reserve the right to release your reserved appointment times or discontinue your care.

FINANCIAL POLICY – MVA

We are unable to carry large balances for patients with little or no guarantee of payment..

PIP COVERAGE: We are required to bill your Personal Injury Protection (PIP) carrier for services rendered regardless of whom was at fault of the accident. If your PIP coverage is exhausted or refuses to pay we will bill your private health insurance company.

THIRD PARTY: We do not bill third party payers. See private pay options below, should your PIP and medical insurance not provide payment for services.

ATTORNEY: If you retain an attorney, you are required to provide us with your attorney's information and agree to the following:
* The patient will authorize and direct their attorney to pay directly to IRG & Affiliates such sums as may be due and owing to them for services rendered to the patient as a result of the accident, and to withhold such sums as may be necessary to pay Integrated Rehabilitation Group, Inc. & Affiliates.
* The patient agrees to notify IRG & Affiliates if their attorney is changed or discharged. The patient also agrees to promptly notify IRG. & Affiliates if a settlement, award, or a verdict is reached and there is a balance due.
* The patient acknowledges that IRG & Affiliates is not responsible and shall not pay any attorney's fees, expenses or costs in connection with the patient's claim or action.

PRIVATE PAY: If your PIP or private insurance fails to provide payment to Integrated Rehabilitation Group Inc & Affiliates, we will bill you directly for the services monthly, 50% if your bill will be due every month. We will defer the monthly payments on balances exceeding $1500. You will be eligible for up to $4000 of treatment with deferred monthly payments. The remainder of the balance will be due at the time of settlement and a guarantee of payment must be on file from your attorney.

SIGNATURE

I understand that I am financially responsible for all charges for services rendered by Integrated Rehabilitation Group, Inc. & Affiliates. I understand that any benefits estimated are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the Financial and Cancellation policy and by signing below I understand and agree to the terms therein.

Patient Name: _____

⇨ Signature _____ Date _____
(Parent or Guardian signature if patient is a minor)

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MEDICAL QUESTIONNAIRE

GENERAL INFORMATION

Name _____ DOB ___/___/_____ Age _____

Date of Injury or Onset of Symptoms: ___/___/_____ Date of Surgery (if applicable): ___/___/_____

Employer: _____ Occupation: _____

Where did your injury occur? ❑ Work ❑ Auto/MVA ❑ Home ❑ Other: _____

Side of Injury: ❑ Right ❑ Left ❑ Bilateral

Briefly describe how your injury occurred: _____

Briefly describe your present symptoms: _____

Does your pain level change over the course of day and night?: _____

Have you had any of the following treatment and/or tests for this condition? *(check all that apply)*

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Home Health ❑ Acupuncture

❑ Hospitalization ❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Injections ❑ Other: _____

Please list the names of practitioners you have seen for this condition:_____

_____

What do you hope to accomplish with therapy? *(your personal goals):* _____

_____

MEDICAL HISTORY *(check all that apply)*

❑ Allergies: _____
❑ Anxiety
❑ Asthma
❑ Arthritis
❑ Blood Clots
❑ Bruise Easily
❑ Cancer: _____
❑ **Other:** _____

❑ Depression
❑ Diabetes
❑ Dizziness/Vertigo
❑ Fibromyalgia
❑ Fractures

❑ Heart Disease
❑ Hepatitis
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV/AIDS
❑ Hypoglycemia
❑ Kidney Problems

❑ MRSA
❑ Multiple Sclerosis
❑ Osteoporosis
❑ Seizures
❑ Sensitivity to heat or ice
❑ Stroke
❑ Traumatic Injury

❑ **No Significant Medical History**

OTHER MEDICAL INFORMATION

Height: _____ Weight:_____ Do you have a pacemaker? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Do you smoke tobacco? ❑ Yes ❑ No If yes, how much_____ how long _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much_____

How would you rate your overall health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you exercise outside of normal daily activities? ❑ Yes ❑ No

List any surgeries/major accidents/illnesses with dates: _____

_____

List all current medications *(or provide front desk with a list that can be copied into your medical record)*: _____

_____

Date Completed: _____