KAIZEN 改善
physical therapy

Basic Patient Information

(IF PATIENT IS UNDER 18 YEARS OF AGE LEGAL GUARDIAN MUST SIGN ALLPAPERWORK)

(Last) _____, **(First)** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Mobile/Work Phone:** _____

Email Address: _____

Date of Birth: ____/____/_____

Employer: _____

Parent/Guardian Information (if under 18 years old):

(Last) _____, **(First)** _____

Relationship: _____ **Employer:** _____

Date of Birth: ____/____/_____ **SSN:** _____-____-_____

Emergency Contact:

(Last) _____ , **(First)** _____

Relationship: _____ **Phone:** _____

How did you find Kaizen Physical Therapy? ☐ Doctor ☐ Family/Friend ☐ Former Patient ☐ LinkedIn ☐ Google Search or Maps ☐ Facebook, Instagram, Twitter, YouTube ☐ Yelp ☐ Other

Patient / Guardian Signature: _____ **Date:**____/____/_____

5025 25th AVE NE STE 201 , Seattle, WA 98105 | p: 206.524.6702 | f: 206.524.6703

KAIZEN 改善
physical therapy

Consent for Treatment

I agree to give my consent for *Kaizen Physical Therapy PLLC.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

Name of Patient: _____
(Please print complete name)

Authorization for Disclosure of Medical Records

I authorize *Kaizen Physical Therapy PLLC.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

eMail Privacy Statement

Kaizen Physical Therapy Therapy's therapists like to stay in close contact with patients. We will be using secure email at times during your treatment to send pertinent information regarding your account, recovery, exercise pictures, and program progress. Our office is committed to your privacy and will not sell, disseminate, or give your email address to 3rd parties.

Information Privacy Statement

Kaizen Physical Therapy PLLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

I understand and agree to *Consent for Treatment, Authorization for Disclosure of Medical Records, and the Information Privacy Statement* above:

Patient / Guardian Signature: _____ **Date:**_____/_____/_____

5025 25th AVE NE STE 201 , Seattle, WA 98105 | p: 206.524.6702 | f: 206.524.6703

Financial Policy Statement

Kaizen Physical Therapy PLLC will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance per your insurance contract.
Co-Pays are always due at the time of service as described in your insurance policy.

Billing Policy for Kaizen Physical Therapy

If we are billing your insurance company please contact your insurance company for information regarding your physical therapy benefits. As a courtesy our office staff will verify insurance coverage, but this is not a guarantee. It is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment. *(Ask our front office if you have questions).*

Balances owed to Kaizen Physical Therapy

- Balances unpaid after 30 days will accrue a $35.00 fee each billing cycle.
- Balances unpaid after 60 days must have payment plan arrangements with our office manager/receptionist.
- Balances unpaid after 91 days will be turned over to our collection agency.

*Checks returned with non-sufficient funds will be charged a $35.00 fee.

Kaizen Physical Therapy Cancellation/ No-Show Policy

- Kaizen Physical Therapy appointments scheduled represent time set aside specifically for you as a patient. Please attempt to cancel any appointment at least **one business day** prior to the scheduled visit. Patients that no-show or cancel on the same day as the scheduled appointment will incur a $**65.00 fee** that must be paid prior to the start of the following appointment.

- By law, all cancellations, and No-shows involving Worker's Compensation claims must be reported to your physician and your claims adjuster.

- Exceptions for cancellations include inclement weather, illness, or death in the family.

I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with *Kaizen Physical Therapy PLLC*. I understand and agree to the financial policy statement, billing policy statement, and cancellation policy.

Patient / Guardian Signature: _____ **Date:**_____/_____/_____

5025 25th AVE NE STE 201 , Seattle, WA 98105 | p: 206.524.6702 | f: 206.524.6703

Appointment Reminders

Indicate below by checking one or more boxes on how you would like Kaizen Physical Therapy to send appointment reminders.

☐ Text Message

☐ Email

☐ Personal Phone Call

Patient / Guardian Signature: _____ **Date:**_____

_____ Check here if you would like your statement/invoice emailed to you.

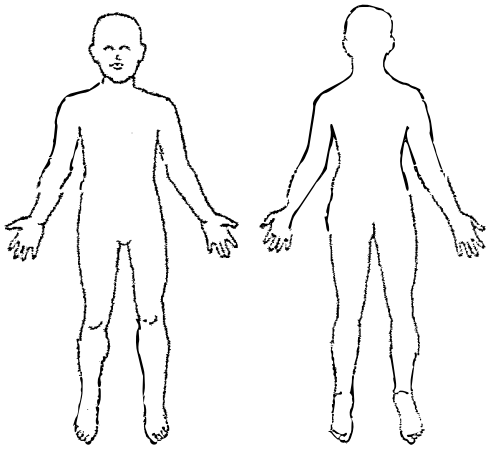
5025 25th AVE NE STE 201 , Seattle, WA 98105 | p: 206.524.6702 | f: 206.524.6703

Kaizen Physical Therapy Patient History

Name_____
Today's Date_____
Age_____ Height_____ Weight_____ Sex: Male/Female Handedness: Right/Left
Occupation_____
Are you currently off work because of this problem? ☐ Yes ☐ No ☐ Light duty
Diagnosis_____ Referral source_____
When did your problems begin?_____
How did your problems begin?_____
_____

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw your pain:



Describe your pain: ☐ Dull ☐ Ache
☐ Sharp ☐ Stabbing ☐ Pins & Needles
☐Shooting Pain ☐ Burning ☐ Throbbing
☐ Twinge ☐ Numbness/Tingling
☐ Other_____
Is your pain constant? ☐ Yes ☐ No
Intermittent? ☐ Yes ☐ No
Fluctuates with activity? ☐ Yes ☐ No
Wakes you up at night? ☐ Yes ☐ No

What makes your symptoms worse?
☐ Sitting ☐ Standing ☐ Walking
☐Lifting ☐ Bending ☐ Lying down
☐ Squatting ☐ Stress ☐ Other_____
Are you ever totally pain free? ☐ Yes ☐ No

What makes your symptoms better? ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Bending ☐ Lying down ☐ Other_____

What time of day are your symptoms worst? _____ Best?_____

Do you feel you are: ☐ Getting better ☐ Getting worse ☐ Staying the same

Have you had this problem before? ☐ Yes ☐ No
If yes, when and how did it get better?_____
_____

Any previous treatment for your current condition? ☐ Yes ☐ No

Have you had diagnostic studies for your current condition? (X-ray, MRI, CT scan...)
☐ Yes ☐ No

Any other orthopedic problems? ☐ Yes ☐ No
If yes, please explain:_____
_____

Any medical problems? ☐ Yes ☐ No
If yes, please explain:_____
_____

Any surgeries? ☐ Yes ☐ No
If yes, please explain:_____
_____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition:_____
_____
_____
_____

Have you ever had a history of any of the following? ☐ Major injury to head/spine ☐ Cancer/tumors ☐ Osteoporosis ☐ Dizziness/blackouts ☐ Heart problems/angina ☐ Diabetes ☐ Pacemaker ☐ Sudden weight loss/gain ☐ Severe pain at night ☐ Smoking ☐ Bruising easily ☐ Asthma ☐ Frequent falls ☐ Loss of bowel/bladder control ☐ Numbness ☐ Seizures/epilepsy ☐ High blood pressure ☐ Coordination loss

Does your current condition limit you in carrying out job duties? ☐ Yes ☐ No
Household duties? ☐ Yes ☐ No

What are your goals in physical therapy?_____
_____
_____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your visit and will help in assessing your condition and guiding your treatment plan.