**Bend To Mend**

Physical Therapy

PATIENT INFORMATION

Name: Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City State Zip

Patients Gender: SSN: DOB: \_\_\_\_\_\_

Marital status: Employer:

Emergency contact: Phone #:

PHYSICIAN INFORMATION

Referring Physician: Phone #: Fax #:

Primary Care Physician: Phone #: Fax #:

Body part injured: Date of injury:

INSURANCE INFORMATION

Insurance company: address:

City: state: Zip:

Insurance member ID #: Group #:

Patient relationship to insured:

AUTO INSURANCE

Insurance company: address:

City: state: Zip:

Claim:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjusters name: Phone #: Fax #:

Carri Kaplan, MPT, COMT, LMP – 6013 Roosevelt Way, Seattle, WA 98115

T:206-334-1824 F:206-319-4572 [www.bend2mend.com](http://www.bend2mend.com),bendtomend@gmail.com

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HEALTH INTAKE:

What problem are you here for today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how/when your problem began?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse – time of day, movement, action, position?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better – time of day, movement, action, position?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe discomfort (circle)

Burning numbness irritating sharp chronic intermittent stabbing cramping

intense Dull tender tight swelling annoying unstable Bruised

What activities increase your symptoms? (circle)

Sitting walking kneeling twisting standing reaching Sit to stand

Lying down lifting bending squatting upstairs downstairs exercise

Have you ever had a similar problem in the past? Did you have treatment for this problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of medical conditions, medications and histories

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Significant traumas/surgeries (type and date), occupational stress

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Do you exercise?

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Goals for rehab?

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NOTICE OF PRIVATE PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information.

THE HEALTH INSUANCE PORTIBILITY AND ACOUNTABILTY ACT OF 1996 (HIPPA)

HIPPA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orally are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used: HIPPA provides penalties for covered entities that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies your private. As obligated by the law, I have prepared this explanation of how I am required to maintain the privacy or your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situations, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONTENT INFORMATION

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment an healthcare operations in the office. I am not allowed to refuse to treat you if you do not sign the consent form. I am permitted to use and disclose your healthcare records for the purpose of treatment and payment

* Treatment means providing coordination or managing healthcare related services by one of more health care providers. For example, I may need to share information with other providers or specialists involved in your care.
* Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment of your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and I am required to honor and abide by that written request: except to the extent that I have already taken actions relying on the authorization.

USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

* When a state or federal law mandates that certain health information be reported for a specific purpose
* For public health purposes, such as contagious disease reporting notices to and from the FDA regarding drugs and medical devices
* Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence
* Uses and disclosers for health oversight activities such as the audits by medicare or for investigation of possible violations or healthcare laws.
* Disclosures in responses to subpoenas or orders of the court
* Disclosers for law enforcement purposes such as to provide information about someone who is suspected to be a victim of a crime or to provide information about a crime at our office
* Disclosure related to workers compensation programs.

YOURE RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following right with respect to your protected health information which you can exercise by presenting a written request to the privacy officer:

* The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members other relatives, close personal friends or any other person identified by you. I am, however, not required to agree to the requested restriction. If I don agree to a restriction, I must abide by it unless you agree in writing to remove it.
* The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address, please provide a written request.
* The right to ask to see or to get photocopies of your health information, you may have to pay for the photocopies in advance. I do charge a fee to complete my written records request for billing or medical records release
* The right to receive an accounting of disclosures to protected health information
* The right to ament you protected health information.
* The right to obtain a paper copy of this notice from me upon request.

**Policy information**

It is my intention to provide you with the best care possible. The following information will acquaint you with procedures with what to expect while you’re in physical therapy.

Appointment information: for your first appointment set aside 60-90 minutes and subsequent appointments are based on your specific needs. This time will include assessment and a discussion on your history, goals, progress and future planning.

Cancellation and lateness policies: your appointment time is reserved exclusively for you. If you are unable to keep your scheduled appointment, please call or email at least 24 hours in advance. My voicemail is available 24 hours per day. I do not accept texts. If you do not cancel with sufficient notice, payment for the entire session you have reserved will be due prior to your next appointment. If you arrive late, we will work through the end of your scheduled session. If I am late, you will receive the full amount of the time for which you are scheduled.

Billing: I will bill your insurance at your request. It is your responsibility to obtain coverage information from your insurance company prior to your first visit. Co-pays are due at the time of service. For cash paying clients, full payment is due at the time of service. I will issue an invoice that you can submit to your insurance for reimbursement.

Client Acknowledgement and informed Consent for Physical Therapy Services: Health care rehabilitation is a mutual endeavor. I cannot guarantee the results obtained, but I will put forth my best efforts on your behalf. Your full cooperation will enhance the rehabilitation process. I, ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request and consent to the physical therapy services and the physical therapy procedures. I understand that I am free to withdraw my consent, and that I may stop treatment of any procedure at any time. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I understand that if I have questions about this information, I should ask. I hereby release Carri Kaplan PT from any and all liability that may occur in connection with the above-mentioned procedures, except for the failure to perform the procedures with the appropriate medical care. I understand that my signature on this form indicates that I have read and understand the preceding information regarding my treatment. I understand the contents of this agreement and agree to abide by these policies.

Patients Name (please Print) ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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