# Shiosaki Physical Therapy

19001 Vashon Hwy SW, Suite 108 / PO Box 1509
Vashon, WA 98070
Phone: 206 408-7398  Fax: 206 259-3107
office@shiosakiphysicaltherapy.com

## PATIENT REGISTRATION FORM

| Last Name: | First Name: | MI: | Date: / / |
|---|---|---|---|

| Gender: ☐M ☐F ☐X | Birthday: / / | ☐Single ☐Married ☐Other | Spouse/Partner: |
|---|---|---|---|

Mailing Address:

| Street | City | State | Zip Code |
|---|---|---|---|

| Primary Contact Phone: | Secondary Contact Phone: | Email: | Social Security Number: |
|---|---|---|---|

Preferred Method of Appointment Reminder Calls: ☐ Text ☐ Phone ☐ Email

| Emergency Contact: | Phone: | Primary Doctor: | Prescribing Doctor(if different): |
|---|---|---|---|

| Employer: | Work Phone: | Occupation: |
|---|---|---|

## INSURANCE/BILLING INFORMATION

To assure payment by your insurance company, please confirm that you have physical therapy coverage and if you require prior authorization for services. Please check the appropriate box:

☐ I do not have insurance coverage that Shiosaki Physical Therapy LLC is contracted with and I will pay the out-of-pocket rate of $115/60 minute visit or $140/evaluation.

☐ I am insured with a plan that Shiosaki Physical Therapy, LLC is contracted with and wish to have claims submitted to my insurance company. I am aware that I will be responsible for any co-pays, coinsurance or deductibles that my plan requires.

## INSURANCE INFORMATION – PLEASE GIVE YOUR CARD TO THE FRONT DESK FOR SCANNING

| Primary Insurance: | Group Number: | Subscriber ID: |
|---|---|---|

| Subscriber birthdate if not yourself | Subscriber name if not yourself: |
|---|---|

## SECONDARY INSURANCE INFORMATION

| Secondary Insurance: | Group Number: | Subscriber ID: |
|---|---|---|

## IF YOU'VE HAD AN ACCIDENT OR WORK INJURY CLAIM THAT PERTAINS TO YOUR CURRENT TREATMENT PLEASE FILL OUT THE INFORMATION BELOW

| Date of Accident: / / | ○ Auto ○ Work | State it occurred: | Claim Number: | Insurance Company: |
|---|---|---|---|---|

| Claims Adjuster: | Phone: | Employer: | Employer Address: |
|---|---|---|---|

| Work Phone: | Other Liability/Potential Lawsuit: |
|---|---|

How did you learn about our service: ____________________

| Name: | Date of Onset: / / | Date: / / |
|---|---|---|

*This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as possible. Your therapist will also provide you with a questionaire specific to your disability to obtain an objective measure of your symptoms and function so we may set therapy goals and monitor your progress.*

## HISTORY OF PRESENT CONDITION

What are your symptoms: ______________________________

______________________________

______________________________

How did your symptoms begin (Please indicate a specific date if possible): ______________________________

______________________________

______________________________

Since onset, are your symptoms getting: ☐ better ☐ worse ☐ not changing

Have you had similar symptoms in the past: ☐ more than once ☐ just this once ☐ no

As the day progresses, do your symptoms: ☐ increase ☐ decrease ☐ stay the same

Pain rating (0= no pain, 5 moderate pain, 10 is emergency room intensity pain.)
Least pain of day ____ Current pain ____ Worst pain ____

Since the onset of your symptoms have you had any problems with: ☐ none of these pertain

☐ Bowel/Bladder ☐ Anal/Genital numbness ☐ Dizziness/Fainting
☐ Weakness ☐ Unexplained Weight change ☐ Night pain/ Sweats
☐ Vision/ Hearing ☐ Malaise/ Vague body discomfort ☐ Numbness
☐ Fever/Chills

What aggravates your symptoms?

☐ Sitting ☐ Lying down ☐ Walking ☐ Stairs ☐ Looking up
☐ Reaching ☐ Housework ☐ Standing ☐ Squatting ☐ Exercise
☐ Sleeping ☐ Yardwork ☐ Coughing ☐ Deep breath

☐ Other: ______________________________

What reduces your symptoms? ______________________________

______________________________

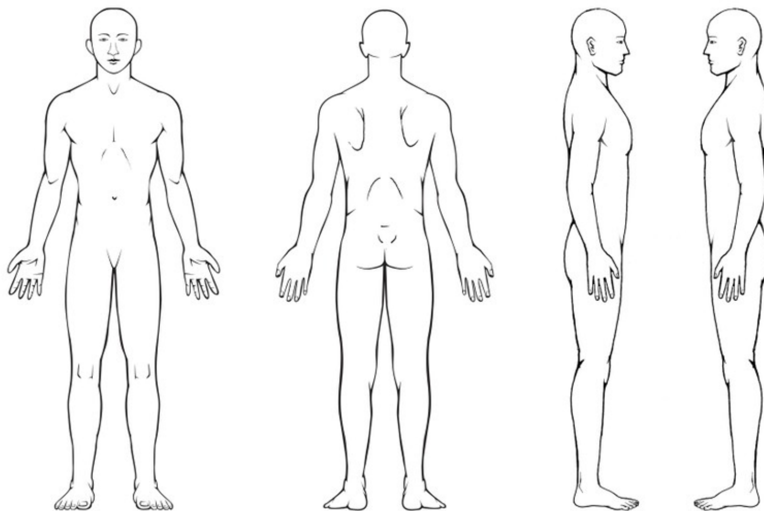
Occupational duties (If this applies): ______________________________

______________________________

Hobbies/Sports: ______________________________

______________________________

Name: Date: / /



Please use the following symbols to indicate on the picture the nature, and area of your pain/symptoms.

S = Sharp
D = Dull
T = Throbbing
A = Aching
N = Numbness/Tingling
C = Constant
O = Occasionally

Have you had any previous treatment for this same condition? Did it help? ______

What Imaging tests have you had for your primary concern? (X-ray, MRI, CT scan, other) ______

## EXISTING OR PREVIOUS CONDITIONS:

| Condition | | | Condition | | | Condition | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | ☐Yes | ☐No | Fractures | ☐Yes | ☐No | Osteoarthritis | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No | Gallbladder Problems | ☐Yes | ☐No | Osteoporosis | ☐Yes | ☐No |
| Anxiety | ☐Yes | ☐No | Head Injury | ☐Yes | ☐No | Parkinson's | ☐Yes | ☐No |
| Asthma | ☐Yes | ☐No | Headaches | ☐Yes | ☐No | Peripheral Neuropathy | ☐Yes | ☐No |
| Autoimmune Disorder | ☐Yes | ☐No | Hearing Impairment | ☐Yes | ☐No | Pregnant? | ☐Yes | ☐No |
| Blood Clot/DVT | ☐Yes | ☐No | Hepatitis | ☐Yes | ☐No | Psychological Conditions | ☐Yes | ☐No |
| Cancer | ☐Yes | ☐No | High Cholesterol | ☐Yes | ☐No | Rheumatoid Arthritis | ☐Yes | ☐No |
| Cardiac Conditions | ☐Yes | ☐No | High/Low Blood Pressure | ☐Yes | ☐No | Ringing In Ears | ☐Yes | ☐No |
| Cardiac Pacemaker | ☐Yes | ☐No | HIV/AIDS | ☐Yes | ☐No | Seizures | ☐Yes | ☐No |
| Chemical Dependency | ☐Yes | ☐No | Incontinence | ☐Yes | ☐No | Sexual Dysfunction | ☐Yes | ☐No |
| Chest Pain | ☐Yes | ☐No | Infectious Disease | ☐Yes | ☐No | Speech Problems | ☐Yes | ☐No |
| Circulation Problems | ☐Yes | ☐No | Kidney Problems | ☐Yes | ☐No | Spinal Cord Injury | ☐Yes | ☐No |
| Depression | ☐Yes | ☐No | Metal Implants | ☐Yes | ☐No | Stress | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | MRSA | ☐Yes | ☐No | Strokes | ☐Yes | ☐No |
| Difficulty Swallowing | ☐Yes | ☐No | Multiple Sclerosis | ☐Yes | ☐No | Thyroid Disease | ☐Yes | ☐No |
| Dizzy Spells | ☐Yes | ☐No | Muscular Disease | ☐Yes | ☐No | Tuberculosis | ☐Yes | ☐No |
| Emphysema/bronchitis | ☐Yes | ☐No | Nicotine Use | ☐Yes | ☐No | Vision Problems | ☐Yes | ☐No |
| Fibromyalgia | ☐Yes | ☐No | Obesity | ☐Yes | ☐No | | | |

If you have answered “Yes” to any conditions above, please give approximate date and description of the problem. Describe any conditions not listed. ______

| Name: | Date: / / |
|---|---|

What prescribed medications, over the counter medications, vitamins or supplements are you taking? (if you have a medication list, we will copy it. Otherwise continue on the back if more space is needed.)

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## SURGICAL HISTORY

| Body Region: | Surgery type: | Date: / / |
|---|---|---|
| Body Region: | Surgery type: | Date: / / |
| Body Region: | Surgery type: | Date: / / |

How many falls have you had in the last year? ☐ None ☐ 1 ☐ 2 ☐ > 2

Any injuries from these falls (where/what)? ______________________________

______________________________

Has dizziness been a factor in the fall(s)? ☐ yes ☐ no

Would you like to have your body mass index determined? ☐ yes ☐ no

## CONSENT TO RECEIVE TREATMENT/MEDICAL RECORDS RELEASE

I consent to and hereby authorize Shiosaki Physical Therapy appropriate personnel to perform the evaluation, care and treatment procedures that are deemed necessary by my request, my physician(s) and other health care providers. I understand that no warranties or guarantees have been made to me about the outcome of my care.

I authorizing Shiosaki Physical Therapy, LLC to release my medical records to my **insurance company**, and **medical professionals** associated with my own or my dependent's care. (Please understand that your records are held in strict confidence and we will not release them to any unauthorized person. Our Notice of Privacy Practices provides further information about how we may use and disclose your protected health information. We encourage you to read it in full.)

Authorizing Signature: ______________________ Date: ____/____/____

## PLEASE INCLUDE THE NAMES OF PERSONAL ACQUAINTANCES WE ARE ALLOWED TO DISCUSS YOUR CONDITION, BILLING, OR SCHEDULING INFORMATION.

| Name: | Relationship: |
|---|---|
| Name: | Relationship: |

Authorizing Signature: ______________________ Date: ____/____/____

| Name: | | Date: / / |
|---|---|---|
| **INITIAL EACH BOX** | **LATE ARRIVAL, LATE CANCELLATIONS, NO-SHOW AND FINANCIAL POLICY; PERSONAL RESPONSIBILITIES** | |
| | We understand unforeseen circumstances can keep you from your appointments at their scheduled time. In such a situation we allow you a grace period of up to 15 minutes without incurring a personal fee of $50.00. Your treatment time will end at its scheduled time so other patients will not have to wait. | |
| | No-shows/Late cancellations that are less than 24 hours prior to the scheduled time will result in a $50.00 fee to be paid prior to your next appointment. This is not covered by your insurance and it is your responsibility no matter what type of insurance you have. | |
| | Two “No-show’s” and/or numerous cancellations will result in the loss of your future scheduled time slots reserved for you. You may call on a day to day basis to see the availability in our schedule for that day. | |
| | I understand that I am financially responsible for all charges, and money owing on my account. This includes any denials, adjustments, co-payments, co-insurance, and/or deductible, services rendered regardless of litigation, insurance reimbursement, or pending claims. | |
| | Payments are to be made at the time of service or after receipt of your finalized bill. Our office personnel can make payment arrangements with you if your financial situation will not allow you to pay your bill in full. If you do not contact us and your account is seriously overdue, it may end up being sent to collections.<br><br>You are responsible to advise us as soon as possible of any changes that may affect your billing, Ex.: new address, employment, injury, or insurance change. Privacy statement | |
| | I understand that the parent/guardian of a minor will be responsible for payment. | |
| | I release Shiosaki Physical Therapy and any of its employees from any and all liability, claims, costs, expenses, injuries or losses, that I may sustain as a result of my participation in exercise programs or home management instructions for my body in the clinic or as part of my home programs. I understand that I am responsible for performing the exercises and management of my body as directed. If an exercise or activity increases my symptoms, I will stop the exercise/activity and notify the therapist so they may modify the treatment program and inform my physician if needed, so that the treatment plan may be safely progressed. | |
| | I understand that I(or my attendant) am not permitted to take pictures of the clinic, other patients, or Shiosaki Physical Therapy personnel. Pictures taken taken for home exercise program may not be posted on social media or other public outlets. | |
| | I understand that Shiosaki Physical Therapy is not responsible for any personal belongings I bring to the clinic. | |
| | I understand that my improvement depends upon following the plan of care devised by the Physical Therapist. Noncompliance including, but not limited to punctuality of each visit, excessive time gaps between visits, and inconsistent participation in home management/exercise programs, can result in termination of care. | |

I hereby consent to treatment and acknowledge that I have read and understand the cancellation, no-show, financial policies and my responsibilities. I am authorizing Shiosaki Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Shiosaki Physical Therapy, LLC for any benefits available under my insurance plan.

Patient Signature: ______________________ Date: ____/____/____

Parent/Legal Guardian Signature: ______________________ Date: ____/____/____

| Name: | Date: / / |
| --- | --- |

## RETURN CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RM), the patient or the Patients responsible party will be responsible for the original check amount in addition to a $25.00 service charge. Once notice is received of the returned check, Shiosaki Physical Therapy, LLC will send a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance, in addition to the $25.00 check service charge.

Parent/Legal Guardian Signature: ______________________ Date: ____/____/____

## CONSENT TO TREATMENT OF A MINOR

I, ______________________ , the parent or legal guardian of my child, ______________________ authorize and consent to physical therapy services from Shiosaki Physical Therapy, LLC for my child. This authorization shall remain effective unless revoked by me in writing.

Parent/Legal Guardian Signature: ______________________ Date: ____/____/____

## CONSENT TO UNENCRYPTED EMAIL CORRESPONDENCE REGARDING YOUR CARE

I understand the risks of unencrypted email and DO give permission to Shiosaki Physical Therapy, LLC to communicate personal health information with me via unencrypted email to the email address I supplied above. I also agree to receiving appointment reminders via text, phone or email.

Patient Signature: ______________________ Date: ____/____/____

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Shiosaki Physical Therapy, LLC clinic for any services furnished to me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other insurance” is indicated in item 9 of HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patent is responsible only for the deductible, coinsurance and non-covered services.

Patient Signature: ______________________ Date: ____/____/____

| Name: | Date: / / |
|---|---|

## NOTICE OF PRIVACY PRACTICES - SHIOSAKI PHYSICAL THERAPY, LLC

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Uses and Disclosures Your protected health information (PHI)** is information that identifies you and that relates to your past, present or future health condition, the care provided, or the past, present or future payment for your health care. Shiosaki Physical Therapy will use your PHI for the purposes of treatment, payment and health care operations. Treatment includes the disclosure of health information to providers who have referred you to me for care, providers to whom I have referred you, or other providers who have been involved in your care. Payment includes the disclosure of health information to your insurance company so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that you care was necessary. Health Care Operations includes the utilization of your records to monitor the quality of care being given at my clinic or for business planning activities. Other special uses: Shiosaki Physical Therapy may use your PHI to contact you by phone, email or mail for scheduling or coordination of care.
**Uses and Disclosures Required by Law:** The federal health information privacy regulations either permit or require us to use of disclose Your PHI in the following ways: I may share some of your PHI with a family member or friend involved in your care if you do not object, I may use your PHI in an emergency situation when you may not be able to express yourself, and I may use or disclose your PHI for research purposes if I am provided with very specific assurances that your privacy will be protected. I may also disclose your PHI when I am required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. I may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, I may release health information about you when it is determined to be necessary by the appropriate military command authorities. I may also release information about you for workers compensation or other similar programs that provide benefits for work-related injury or illness. Your authorization is required before your PHI may be used or disclosed by me for other purposes.
**Your Privacy Rights Restrictions:** You have the right to request restrictions on how your PHI is used however; I am not required to agree with your request. If I do agree, I must abide by your request.
**Confidential Communications:** You have the right to request confidential communications from me at a location of your choosing. This request must be in writing.
Access to your PHI: You have the right to request a copy of your medical record. You must make this request in writing and I may charge a fee to cover the costs of copying and mailing.
**Amendments:** You have the right to request an amendment be made to your PHI, if you disagree with what is says about you. This request must be made in writing. If I disagree with you, I am not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your medical record. I may not amend parts of your medical record that I did not create.
**Accounting of Disclosures:** You have the right to request an accounting of the disclosures I have made of your PHI. These disclosures will not include those made for treatment, payment or health care operations or for which we have obtained authorization.
**Complaints:** If you feel that your privacy rights have been violated, you have the right to make a complaint to Shiosaki Physical Therapy in writing without fear of retaliation. Your complaint should contain enough specific information so that I may adequately investigate and respond to your concerns. If you are not satisfied with my response, you may complain directly to the Secretary of Health and Human Services.
Office of Civil Rights US Department of Health and Human Services
2201 Sixth Ave - mail stop RX-11
Seattle, WA 98121
(206) 615-2290; (206) 615-2296; (800) 368-1019; TDD: (800) 537-7697

My duty to Protect Your Privacy: Shiosaki Physical Therapy is required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require me to provide you with this document, Notice of Privacy Practices - Shiosaki Physical Therapy, LLC. I reserve the right to update this notice if required by law. If I do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from me.
Privacy Contact: If you would like more information about our privacy practices or wish to file a complaint please contact
Shiosaki Physical Therapy at PO BOX 1509 Vashon, WA 98070
Phone: 206-408-7398, Fax: 206 259-3107.

**I have reviewed and I agree to the Notice of Privacy Practices of Shiosaki Physical Therapy, LLC**

Patient Signature: ______________________ Date: ____/____/____