Peeples Physical Therapy and Fitness Clinic

414 Girard Street, Bellingham, WA 98225

Phone 360.733.5155 Fax 360.733.1165 www.peeplesfitness.com

ICD10:_____
Eval: _____

Patient Registration

Patient's Full Name: _____

Patient's Social Security Number: _____ Sex: _____ Age: _____

Mailing Address: _____ Apt #: _____ Birthdate: ___/___/___

City/State/Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Student

Emergency Contact: _____ Relationship to Patient _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about Peeples Physical Therapy? ☐ Doctor Referral ☐ Family Friend Other: _____

Primary Insurance Company: _____

Subscriber's Name: _____ Date of Birth: ___/___/___

Subscriber's Relationship to Patient: _____

Subscriber #: _____ Group #: _____

Secondary Insurance Company: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Relationship to Patient: _____

Subscriber #: _____ Group #: _____

Work Injury? ☐ Yes ☐ No L&I Case # (if known): _____

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Health History

Name: _____ Today's Date: ___/___/___ Date of Birth: ___/___/___

Current Weight: _____ lbs Height: _____ Recent weight gain/loss: _____ lbs

SSN: _____

1. Major Complaints:
   a. _____
   b. _____
   c. _____
2. Any recent hospitalizations? List Dates: _____ Reason: _____
3. Medical History (Check all that apply)

☐ Diabetes	☐ Hypertension	☐ Urinary Troubles
☐ Alcoholism/Drug Abuse	☐ Pacemaker	☐ CVA
☐ Allergies	☐ Liver Disease	☐ Mental Illness
☐ Anemia	☐ Hearing Loss	☐ Pulmonary Disease
☐ Bowel Troubles	☐ Circulatory Problems	☐ Heart Disease
☐ Cancer	☐ Renal Disease	☐ Compromised Immune System

4. What medications are you currently taking? (attach list if necessary) NSAIDS?

_____

_____

Additional Comments:

_____

_____

I have read a copy of the Notice of Privacy Practices statement for Peeples Physical Therapy and Fitness Clinic Inc. By signing below I demonstrate that I understand and agree with the statements made by this clinic.

Patient Signature: _____ Date: ___/___/___

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Informed Consent for Services

Client Name: _____

Thank you for selecting Peeples Physical Therapy for your rehabilitation needs. The time I have reserved for your treatment is important to me. In order to provide the same consideration to all of my clients, please read and sign the following agreement:

Consent for Treatment: I voluntarily consent to evaluation and treatment which my physician or designees determine to be necessary. I acknowledge that no guarantees have been made to me as a result of evaluation or treatment in this facility.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved in my current treatment. I understand that facility personnel may release the fact that I am presently a client here, without disclosing confidential information, so that I may receive phone calls.

Insurance Consent: I request that payment of authorized benefits be made to Peeples Physical Therapy and Fitness Clinic for any services furnished to me. I authorize this facility to release to Medicare and or accident or health insurer medical or financial information as needed for claims processing, fraud investigation or quality care review. I understand that I may revoke this consent for information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Pre-certification / Prior Authorization Agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company regarding any pre-certification and prior authorization requirements.

Guarantee of Account: I agree to pay Peeples Physical Therapy and Fitness Clinic for all charges not covered by any third party payer.

If you are unable to make your appointment on time or have to cancel your appointment, please call Peeples Physical Therapy at 360.733.5155 as far in advance as possible.

You may be charged a cancellation fee of $100 if you do not notify us 24 hours in advance of your cancellation. Missed appointments may be charged a $130 fee.

_____ _____ _____

Client Signature** (or legal representative)* ***Relationship to Client ***Date***