

Quality Care Physical Therapy, Inc
19102 North Creek Parkway, Suite 104
Bothell, WA 98011
425-486-6079

DATE: _____ REFERRING DOCTOR: _____

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Date of Birth _____ Sex M ___ F ___

Marital Status: M ___ S ___ D ___ Spouse's Name _____

Is this a work related injury? Yes _____ No _____ Date of Injury _____

Is this an auto accident related injury? Yes _____ No _____ Is there an attorney involved? Yes ___ No ___

PATIENT WORK INFORMATION

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Work Phone Number _____ Extension _____

Employee Id Number _____ Occupation _____

PRIVATE INSURANCE INFORMATION

Is this your coverage? Yes ___ No ___ If no, whose name is covered _____

Your relationship to the insured _____ Policy Number _____

Group Number _____ Certificate Number _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship _____
Insurance Policy Number _____ Group Number _____
Insurance Company Name _____ Phone # _____
Ins. Co. Address _____
City _____ State _____ Zip Code _____

AUTO INSURANCE INFORMATION

Name of Insured _____
Auto Insurance Company Name _____
Address _____
City _____ State _____ Zip Code _____
Policy Number _____ Claim Number _____
Adjustor's Name _____ Phone Number _____

WORKER'S COMPENSATION INFORMATION

Employers Name (at time of injury) _____
W/C Insurance Name _____ Phone# _____
Address _____
City _____ State _____ Zip Code _____
Claim Number _____ Adjustor Name _____

ATTORNEY INFORMATION

Name _____ Phone # _____
Address _____
City _____ State _____ Zip Code _____

AUTHORIZATION TO PAY QUALITY CARE PHYSICAL THERAPY

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to QUALITY CARE PHYSICAL THERAPY and I am financially responsible for non-covered services. I also authorize QUALITY CARE PHYSICAL THERAPY to release any information to process this claim.

SIGNED: _____ DATE: _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that I will reimburse Quality Care Physical Therapy a fee of **\$50.00** if I do not arrive for my previously scheduled treatment or cancel my treatment without a 24 hour notice. I also understand that Quality Care Physical Therapy may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment. Returned check fee: \$25.00 per occurrence.

SIGNED: _____ DATE: _____

CONSENT TO USE AND/OR DISCLOSURE OF PATIENT INFORMATION

As a patient of **Quality Care Physical Therapy, Inc**, you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of Patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practices before signing this form. A copy of this Notice was made available to you along with the Consent. If you do not have a copy of the Notice you can request one from us at the address and phone number given below.

We may change our Notice of Privacy Practices from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you come in for an appointment. You may obtain a copy of our current Notice upon request to our address and phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practices explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care; and conduct certain kinds of administrative health care operations. By signing this Consent below, you agree that we may use or disclose information about you for these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number given below if you want more information or to request additional restrictions.

You have the right to revoke this Consent at any time, but must do so in writing. A revocation of this Consent will not apply to any use or disclosure of information which happened before we received your written revocation. Please contact us at the address and phone number below if you want more information, or to revoke this Consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

Name of Patient

Patient Signature

Date

Practice Name: Quality Care Physical Therapy, Inc.
Practice Address: 19102 North Creek Parkway, Suite 104
Bothell, WA 98011
Practice Phone: (425) 486-6079