Squak Mountain Physical Therapy, Inc.
5825 221st Pl. SE #206 Issaquah, WA 98027
Phone: (425) 392-8335 * Fax (425) 392-8338
www.squakmountainpt.com

Patient Information (Please Print)

Name ____ Date ____/_____/________

Address ____

City ___________________________________ State _____________ Zip ________________

Home Phone ___________________ Work Phone ___________________ Cell Phone _____________________

Email Address:____

Do you prefer billing statements by: ☐ E-mail ☐ Postal Mail

May we have your permission to contact you via email for office related correspondence? Yes / No

Social Security Number ________-______-________ Date of Birth _____/_____/_______ Age ________________

Sex: M / F Martial Status S /M / D/ W Spouse/Partner Name________________________________

Employer ________________________________ Spouse/Partner Employer ____________________________

Who Referred You to This Office? ____

Family or Primary Care Physician ______________________________ Phone Number _____________________

Emergency Contact Name____________________________________ Phone Number______________________

Reason for your Visit

☐Non-Injury Related Condition Date: ______________

☐Injury Date ________ Injury Place: ☐Home ☐Work ☐Other_________ ☐MVA (State occurred ______)

Insurance Information (please circle type) Medical Insurance / Worker's Comp / MVA

Primary Insurance Name____Phone Number________________
Subscriber's Name ____Date of Birth ____/______/_______
Relationship to Patient: Self / Spouse / Parent / Other
Insurance ID or Claim Number (incl any letters) ______________________________ Group #________________
Claim Manager or Adjuster's Name __________________________________ Phone Number ________________

Secondary Insurance Name ____Phone Number________________
Subscriber's Name ____Date of Birth ____/_____/_______
Insurance ID or Claim Number (incl any letters)____________________________ Group #___________________

Additional Information

Have you had any other Physical Therapy treatment this year? ☐ Yes ☐No # of Visits ______
Have you had any of the following treatment this year? (OT, LMT, LAC) ☐ Yes ☐No # of Visits ______
Have you had any Chiropractic treatment this year? ☐ Yes ☐No # of Visits ______

Patient Responsibility and Consent Form

Insurance Billing

Squak Mountain Physical Therapy (SMPT) verifies your insurance benefits with your insurance company as a courtesy, but does not guarantee any information given to us. If the information provided to us is inaccurate, or your employer/insurance company changes their mind regarding your coverage, you will be responsible to pay for services rendered. We recommend you contact your insurance company for any clarification of your eligibility and/or physical therapy benefits. If you have billing questions for our office, please call Denise at (425) 691-8193 or email her at businesshealth@gmail.com.

Financial Responsibility and Assignment of Benefits

I understand that insurance billing is provided as a courtesy and that I am financially responsible for all charges related to my treatment at SMPT. I understand that exact insurance benefits cannot be determined until my claim has been processed by my insurance company. I agree to accept financial responsibility for all medical services and supplies received.
Patient balances are due within 30 days of your insurance plan paying the claim. Accounts with no activity for 60 days may be forwarded for collection activity. If I default and my account is referred for collections, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees.

Patients with unmet deductibles of $300 or more must make a minimum payment of $100 per visit until the deductible is met. These payments will be applied accordingly after your insurance processes the claims. If at any time it is determined that the patient has made an overpayment, SMPT will either promptly refund the credit or apply it to future visits at the patient's discretion. Co-Pays are due at the time of service. NSF checks are subject to a fee of $25.00.

I authorize direct payment from my insurance plan to SMPT for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as worker's compensation or insurance contract denies payment for any services or supplies, I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for timely payment from my third-party payer.

Worker's compensation and MVA claims are billed directly to the responsible party. However, please be aware that you may be held responsible if your claim is later denied or your MVA or PIP maxes out.

Cancellation/No Show Policy

In order to best serve our patients, it is necessary to provide 24-business hours notice to change any appointment. Our late cancellation or no-show fee of $40 will be due at your next appointment and will not be covered by any insurance plan. We do understand that emergencies do occur and we reserve the right to waive this fee.

Notice of Privacy Practices

I hereby acknowledge I have been offered a copy of the Notice of Privacy Practices for SMPT. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.

Consent for Treatment and Release of Information

I consent for treatment and authorize the release of information, verbal and written, contained in my medical record, and other related information, to any insurance carrier or its intermediaries, my attorney, employer, school, and any related healthcare providers and all other related persons as it relates to my treatment and/or payment for services rendered. No guarantees have been made to me about the outcome of this care.

Signature ____ Date _____/_____/_________
Parent/Legal Guardian Signature _____________________________ Date_____/_____/_________