OLYMPIA PHYSICAL THERAPY & INDUSTRIAL REHABILITATION, INC.
and HAWK'S PRAIRIE PHYSICAL THERAPY

(Please Print Legibly)

DID YOU FIND US THROUGH A YELLOW PAGES AD? If so, please indicate which directory:	❑ QWEST/DEX	❑ OTHER BOOK

Did you choose us for another reason? Please specify:	❑ Friend or Family	❑ Attorney	❑ Doctor	❑ Location	❑ Other	NAME: _____

EMAIL ADDRESS: _____ @ _____ . _____

DATE OF INJURY ____/____/____ | Cause of Injury : ❑ Motor Vehicle ❑ On-the-job ❑ Other _____

PATIENT INFORMATION

Patient's Last Name	First	MI	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Home Phone ( )	Mobile Phone ( )	Social Security Number	Date of Birth / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code
P.O. Box	City	State	ZIP Code

Employer Name and address	Employer Phone No. ( )

RESPONSIBLE PARTY (if different than patient)

Last Name	First	Date of Birth / /	Address (if different)	Home Phone No.

Occupation	Employer	Employer Address	Employer Phone No. ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name and Address	**Phone No.**

Subscriber's Name	Subscriber's S.S. #	Date of Birth / /	Group or CLAIM #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Date of Birth	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

~ OVER ~

BY SIGNING THIS FORM I, the patient/parent/guardian, AGREE THAT:

I authorize physical therapy treatment and procedures provided by an authorized employee of Olympia Physical Therapy & Industrial Rehabilitation, Inc. (OPTIR) and/or Hawk's Prairie Physical Therapy (HPPT), as directed by my physician's prescription, and authorize all insurance benefits to be paid directly to OPTIR or HPPT.

I understand I am responsible to know my insurance coverage and I assume all financial responsibility for the balance of any charges not covered by my insurance.

I agree that all co-payments are due at the time of service. If I fail to pay co-payments at the time of service, there will be a one-time billing statement that will include a $10 non-negotiable service charge, after which, any unpaid balance will be turned over to a professional collection agency. All returned checks will be assessed a $40 fee, per return, which will also be turned over to a professional collection agency, should they remain unpaid within ten days of my being notified of the dishonored instrument.

Furthermore, **I understand that all accounts not paid in full at the time of service are due and payable within 30 days.** Accounts remaining unpaid beyond 30 days are subject to a minimum finance charge of the greater amount of $5.00 or 1% per month (12% per annum), and probable assignment to Dynamic Collectors, Inc.

I agree that any dispute over my account will be governed by Washington State law, that the agreed venue for disputes will be Thurston County, and I agree to pay all collection costs and reasonable attorney fees associated with any dispute that may arise from my failure to pay my account in full. *Accounts assigned to a professional agency incur an additional $25 collection fee that will be charged to my account.*

I assign OPTIR and HPPT the authority to release any information necessary for the purpose of processing medical claims and collecting unpaid balances on my account, and release OPTIR and HPPT from disclosure of the patient's record as provided by this paragraph.

RELEASE OF LIABILITY

IN CONSIDERATION of my being involved in a physical therapy program which permits use of the facility and equipment of Olympia Physical Therapy & Industrial Rehabilitation, Inc. (OPTIR), located at 2755 Mottman Road SW, Tumwater, Washington, and/or Hawk's Prairie Physical Therapy (HPPT), located at 8750 Talon Lane E, Suite C, Lacey, Washington, the undersigned hereby fully understands and agrees to the following conditions prior to participating in physical therapy treatment:

I agree to indemnify, defend, hold harmless and release OPTIR and HPPT, its elected and appointed officers, agents, employees, and volunteers from any and all lawsuits, damages, claims, judgments, losses, liability or expenses arising out of (1) the death of, personal injury, or property damage to myself (or my minor child), which may be sustained while using property or equipment owned by or under the control of OPTIR and HPPT, or (2) any death or injury which results or increases by any action taken to medically treat me (or my minor child). All of the terms above shall apply whether or not caused by the alleged negligence, whether active or passive, or any acts or omissions of OPTIR and HPPT, or any of its elected or appointed officers, agents, employees or volunteers.

I also understand that there are risks associated with participation in a physical therapy program, and I assume the risk of any injuries that I (or my minor child), may sustain during any of the activities that may be engaged in during the course of treatment. I know there is the risk of injury or death involved in my participation in a physical therapy program at OPTIR and HPPT and;

I voluntarily participate in a physical therapy program at OPTIR and HPPT, and I sign my name below so that I may participate – I understand that I can choose not to sign this agreement by choosing not to participate;

I acknowledge that if anything happens to me (or my minor child) while participating; including injury or death, I release OPTIR and HPPT, and any of its employees from liability; and; if I (or my minor child), are injured while participating, I agree that anyone who provides medical assistance shall not be liable if they cause my (or my minor child's) death or cause me (or my minor child) increased, or additional, injury(ies).

I have read, understand and approve this RELEASE FROM LIABILITY. IF the participant is a minor, the undersigned parent or legal guardian warrants and represents that this RELEASE, its significance, and the assumption of risk, has been explained to and understood by my minor child or ward; and hereby declare, under penalty of perjury, that I am the parent or legal guardian of the named participant and am authorized to sign this document on their behalf.

PATIENT SIGNATURE	DATE
PATIENT/GUARDIAN SIGNATURE	DATE
PARENT NAME (PRINTED)	PATIENT NAME (PRINTED)

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PHYSICAL THERAPY
& Industrial Rehabilitation, Inc.

FCE

HEALTH INFORMATION QUESTIONNAIRE

Name: _____ Date: _____

What area are we treating? _____ Height: _____ Weight: _____lbs

If you were injured, how did the injury occur? _____

_____ Date of injury/surgery: _____

Yes	CONDITION	WHEN	Yes	CONDITION	WHEN	Yes	CONDITION	WHEN
	Arthritis			Heart Disease			Polio	
	Asthma			Hepatitis			Rheumatic Fever	
	Bladder Infection(s)			High Blood Pressure			Seizure Disorder	
	Bronchitis			Immune Deficiency Illness			Spinal Cord Injury	
	Cancer			Kidney Disease			Sprain/Strain	
	Cerebral Palsy			Low Back Injury			Stroke	
	Congenital Anomalies			Multiple Sclerosis			Surgery	
	Diabetes			Muscular Dystrophy			Ulcers	
	Gastrointestinal Problems			Neck Injury			Fibromyalgia	
	Head Injury			Pneumonia			Other:	

PLEASE EXPLAIN ANY YES ANSWERS (e.g. TYPE OF SURGERY, MULTIPLE EPISODES, ETC.)

_____

_____

List all medications you are currently taking: _____

_____

In an effort to tailor your treatments to your individual needs, please answer the following questions (circle answer):

Do you have concerns about exercising in a group environment? YES NO OTHER: _____

How do you learn best? Listening Reading Doing

Do you have any special personal concerns that need to be addressed during your treatment with us?

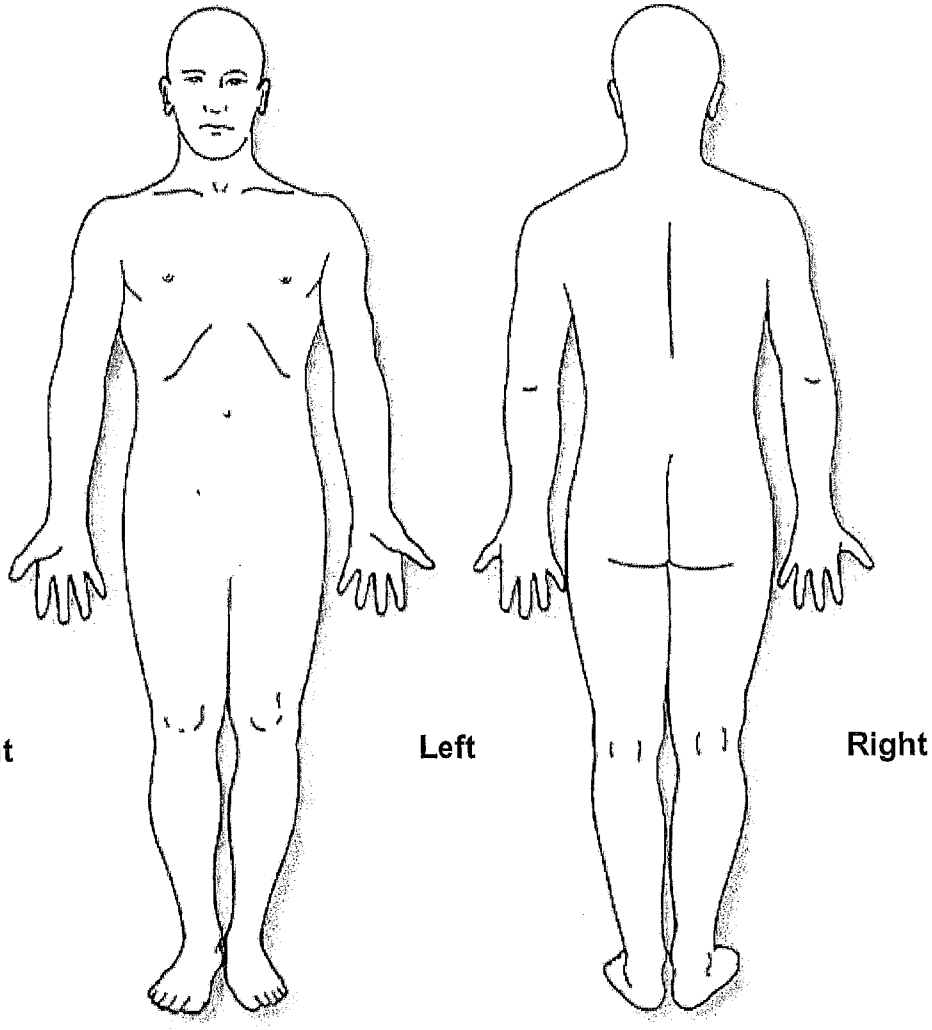
YES NO If yes, please explain: _____

_____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

Where is your pain?

Please use the key below to indicate on the drawing the nature and areas of your pain.



KEY

Numbness	
Severe Pain	
Moderate Pain	
Shooting Pain	
Pins and Needles	

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PHYSICAL THERAPY
& Industrial Rehabilitation, Inc.

PHYSICAL CAPACITY EVALUATION
INFORMED CONSENT

You are going to be given a "Physical Capacity Evaluation" which is a series of test of strength, flexibility, endurance, cardiovascular fitness, material handling ability, coordination, static posturing, repetitive movements, and any other tests, which will help determine your safe maximum ability to work. All the tests are voluntary and you may refuse any test if you feel you are not capable of performing it. All the tests will be thoroughly explained to you before you are asked to perform them.

You are not expected to experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the evaluation and stop any test before any increase in your current level of pain or discomfort.

There are inherent risks with a Physical Capacity Evaluation because you will be asked to exert effort, handle weights, and perform activities with increasing degrees of difficulty which could cause an increase in your current level of discomfort, or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any test by stopping if you feel any increase in pain or discomfort. You will also be able to stop testing if you feel any discomfort in any other part of your body. The evaluator will take every precaution to ensure that you are protected from any potentially hazardous situations and you will never be forced to perform any test that you do not wish to perform.

The Physical Capacity Evaluation process contains tests to determine if you are cooperating to determine your best work ability. Any indication that you are not giving your best effort will be reported along with the results of this evaluation.

Based on the above information, I agree to cooperate fully and to participate in the Physical Capacity Evaluation to help determine my actual safe working ability.

_____ _____

Patient's Signature Date

_____ _____

Evaluator's Signature Date

2755 Mottman Road SW, Tumwater, WA 98512 • 360/352-5077 Fax 360/352-5022

Acknowledgment of Receipt of Privacy Practices

I, _____, agree that Olympia Physical Therapy & Industrial Rehabilitation, Inc., Hawks Prairie Physical Therapy and Northwest Sports Medicine (hereby referred to as ***OPT AND AFFILIATES***) will use or disclose my health information for, billing, treatment and healthcare operations. I have received a copy of ***OPT AND AFFILIATES'*** privacy practices. I have been informed of my right to request restrictions on use and disclosure of my health information.

By signing below, I acknowledge that I have received a copy of ***OPT AND AFFILIATES'*** privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

In lieu of patient signature, I, _____, a staff member of ***OPT AND AFFILIATES',*** state that _____ was provided with a current copy of our privacy practices.

OR

Acknowledgment of receipt of the ***OPT AND AFFILIATES'*** Privacy Practices was not received because _____

_____

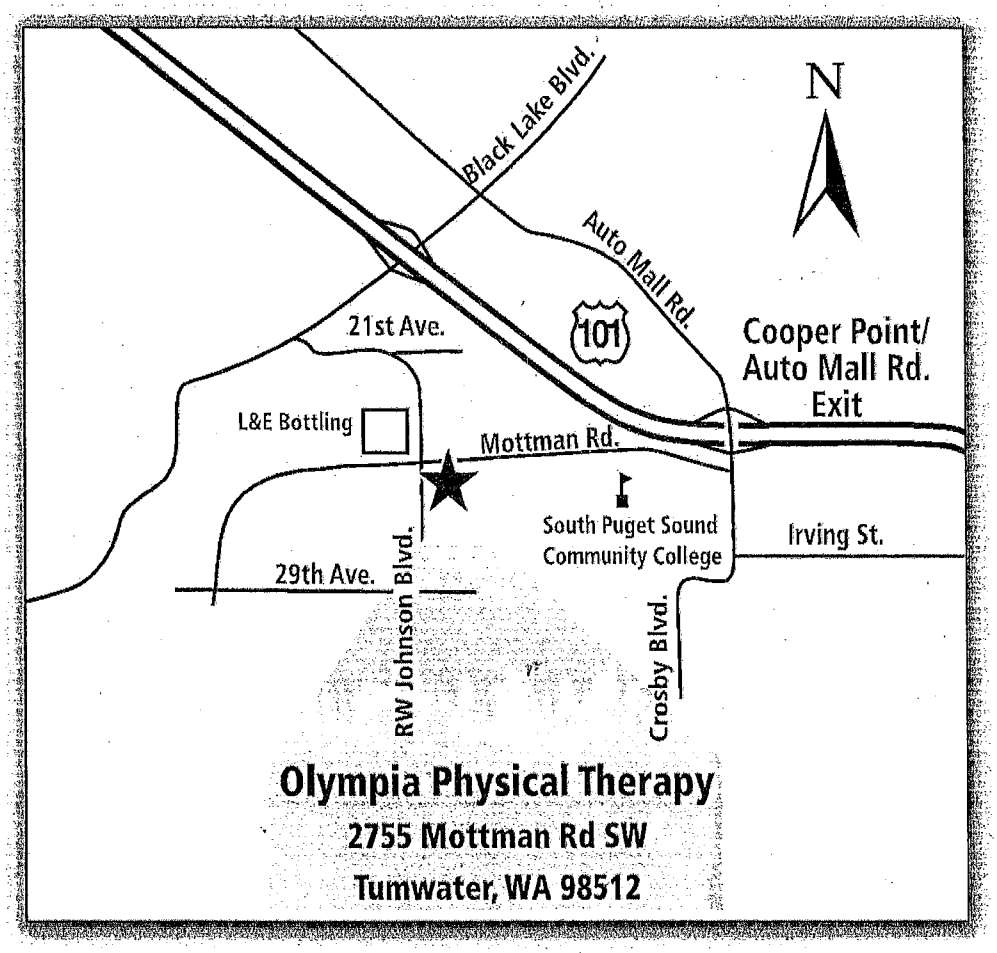
Employee Signature _____ **Date** _____

Federal privacy laws limit our access to your health insurance information, including specific limits on physical therapy coverage. While we do our best to keep you informed of your health insurance company's limitations on physical therapy, it is important that you contact your health insurance carrier for a complete declaration of benefits to avoid unexpected healthcare expenses you will be responsible for.

DIRECTIONS TO:

Olympia Physical Therapy & Industrial Rehabilitation, Inc.

Our office is located at 2755 Mottman Road SW, in Tumwater, Washington. To get to our office from I-5, north or south, take Exit 104, heading west on I-101. Take the first exit, Cooper Point Rd/Auto Mall/Crosby Rd. exit, turn left and go over the freeway. If you are heading east on 101 turn right at this exit and right onto Crosby Rd. Take a right at Mottman Road and follow Mottman approximately .07 miles. Our office is located on the left, just before the stop sign at the intersection of Mottman and RW Johnson Road. L & E Bottling is located diagonally across the street from our clinic.



Telephone: (360)352-5077 OR toll free 1 (866)816-10PT
Fax: (360)352-5022