Kinetic Elements Physical Therapy

4250 8th Ave NW Suite 100 Seattle WA 98107

Patient Registration – Please Print

PATIENT _____ **DATE** _____
Last First Middle Initial
ADDRESS_____
EMAIL _____ **MARITAL STATUS Single Married Other**_____
PHONE _____ _____ _____
Home Work Cell
BIRTHDATE_____ **SEX Male Female**
DRIVER'S LICENSE#_____
EMPLOYED Full Time / Part time STUDENT Full Time / Part Time
EMPLOYER/SCHOOL NAME

_____
EMPLOYER'S ADDRESS

_____
EMERGENCY CONTACT _____ **RELATIONSHIP TO PATIENT**_____
PHONE _____ _____ _____
Home Work Cell

INSURANCE INFORMATION – PLEASE PROVIDE YOUR CARDS FOR COPYING

PATIENT'S RELATIONSHIP TO INSURED: **Self / Spouse / Child / Dependent**

IF INSURED IS NOT THE PATIENT, PLEASE COMPLETE THIS SECTION

NAME OF INSURED _____
(Subscriber Name) Last First Middle initial
BIRTHDATE_____
Sex: Male / Female
PATIENT'S RELATIONSHIP TO INSURED: **Self / Spouse / Child / Dependent**
INSURED'S ADDRESS

_____
EMPLOYER

PRIMARY INSURANCE Co. _____**ID Number** _____ **Group number**_____
SECONDARY INSURANCE Co. _____**ID Number** _____ **Group number**_____
NOTE: we do not bill for secondary insurance plans. We require this information to ensure your provider is credentialed with your secondary insurance plan.

IS PATIENT'S CONDITION RELATED TO: Employment / Auto / Accident / Other _____
DATE OF CURRENT ILLNESS INJURY:
MONTH _____**DAY**_____ **YEAR**_____

REFERRING PROVIDER (Doctor, Naturopath, Chiropractor, Etc.)

_____ _____ _____
Referring Provider Name **Phone** **Fax**

REFERRING PROVIDER'S ADDRESS

_____

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

LABOR AND INDUSTRY CLAIM NUMBER:

_____

CLAIM MANAGER: _____

PHONE (w/area code) _____

IF THIS IS A PERSONAL INJURY CLAIM, PLEASE FILL OUT THE FOLLOWING INFORMATION

NAME OF AUTO INSURANCE COMPANY:

_____

ADJUSTER/CLAIM MANAGER NAME: _____

CLAIMS ADDRESS:

_____

Street City State Zip

PHONE _____

CLAIM # _____

We thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your physical therapy insurance benefits, and enable us to process your claim in a timely basis.

→Please note that Co-pays are collected at the time of visit.
→Reminder that we do not bill secondary insurance.

Patient's or authorized person's signature:

- **I authorize the release of any medical records or other information necessary to process this claim.**
- **I authorize payment of medical benefits to Kinetic Elements Physical Therapy.**
- **I am financially responsible for any balance due.**

Signed _____ Date _____

CONSENT FOR CARE AND FINANCIAL AGREEMENT

I (patient or legal guardian for patient who is minor) grant permission for Kinetic Elements Physical Therapy to perform such examinations and therapeutic procedures as may be professionally deemed necessary or advisable for appropriate evaluation and treatment of my condition.

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional persons I would like my health information to be made accessible to are noted below.

As permitted by HIPAA, I authorize the release of any and all of my medical records to my insurance company at their request. Other release is subject to my written consent.

I understand that all treatment fees are to be paid at the time of service unless other billing arrangements are made with Kinetic Elements Physical Therapy. Kinetic Elements Physical Therapy is a preferred provider with most major insurance companies. In cases where your insurance is not billed or Kinetic Elements Physical Therapy is not a preferred provider, Kinetic Elements Physical Therapy will provide, on request, a superbill receipt that you may use to submit to your insurance carrier and/or keep for your personal records.

If my insurance company (or other responsible party) rejects payment or shows that a portion is the responsibility of the patient, I agree to make full payment within 30 days of the first billing unless other arrangements are mutually agreed upon. Exception will be made in cases where Kinetic Elements Physical Therapy contract with the insurer precludes this.

If I "no-show" or cancel an appointment without providing 24 hours of notice (excluding weekends), I am responsible for paying the cancellation fee of $60 before further treatment is provided. These charges cannot be billed to insurance. Exceptions for emergent situations may be made. If I "no-show" two times, I understand that further appointments will be cancelled.

I request that all fees paid by my insurance company or other party be paid directly to Kinetic Elements Physical Therapy unless I have previously paid said fees directly to Kinetic Elements Physical Therapy.

Co-pays are due at the time of service.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.
Signature _____ Date_____

For the best chance of reimbursement from your insurance carrier, w*e suggest that you contact your insurance company prior to your first appointment to determine your physical therapy coverage and providership stipulations.*

I authorize the following persons to have access to my health information:

_____

_____

I HAVE RECEIVED, READ AND UNDERSTAND MY PRIVACY RIGHTS AND PRACTICES (HIPAA).
Signature _____ Date_____

BILLING INFORMATION WORKSHEET

In order to fully understand physical therapy coverage under your insurance plan, we have developed this worksheet to be completed PRIOR to your first visit.
NOTE: You are responsible for obtaining this information from your insurance company. We thank you for your assistance in this matter.

• Insurance plan name or program name: _____
• Member ID number: _____ Group number: _____
• Customer Service phone number _____
• Name of customer service representative: _____
• Insurance claim address: _____
• Date eligibility began: _____
• Deductible: $_____ Co-pay: $_____ Co-insurance: %_____
• Maximum allowable benefit for physical therapy: $_____ # visits _____
• Remaining $_____ # visits _____ for current year as of _____
• Does this plan require a ***referral*** from the ***primary care physician*** to Kinetic Elements Physical Therapy for payment of services? Yes/No
• Does this plan require a ***prescription*** from the ***primary care physician*** to Kinetic elements Physical Therapy for payment of services? Yes/No
(NOTE THAT A PRESCRIPTION AND REFERRAL ARE NOT ONE AND THE SAME).
• How often does the referral/prescription need to be updated to ensure continuous coverage? (i.e., every 2 weeks, every month, every three months, etc.) _____
• If your company is an HMO or PPO, and we are NOT an in-network provider for the plan, what is the benefit coverage for Kinetic Elements Physical Therapy?
(i.e., 60%, 80%,etc.)._____%