



www.rehabissaquah.com
425-394-1200
Fax 425-394-0100
1495 NW Gilman Blvd Ste 4
Issaquah, WA 98027

Dear New Patient:

We look forward to meeting you and assisting with your medical care. In order to provide comprehensive, coordinated and efficient care, some preparation is required prior to your first visit. The forms that need to be completed prior to your visit are included in this packet.

Information for the day of your appointment:

1. Rehabilitation Options of Issaquah is located at 1495 NW Gilman Blvd, #4, Issaquah, WA 98027. Directions are provided on the website.
2. Please arrive 15 minutes before your scheduled appointment time in order to complete registration process (allow longer if you could not complete the pre-visit forms in advance.)
3. Items to bring with you:
 - a. The attached forms (completed): Patient Registration Form, Medication Policy Form, HIPPA Form, and Financial Policy Form. If you have been involved in a motor vehicle accident, please fill out the Auto Accident Questionnaire. Depending on your insurance company there may be additional forms you must fill out during registration process.
 - b. Picture ID
 - c. Insurance Card and Co-Pay. If you do not have these at the time of your appointment we would be happy to reschedule your appointment for another day.
 - d. A referral from your doctor if your insurance requires it. If you do not know if your insurance plan requires a referral to see a specialist, call the number on the back of your insurance card.
 - e. Prior medical information that could help us find answer for you (i.e. lab results, office or hospital records, radiology reports, etc.) Please do not bring in films.

Insurance and Billing information:

We accept most forms of insurance and will bill your insurance company directly on your behalf. We do suggest you contact your insurance company prior to your appointment to verify your coverage and make sure you do not need to collect a referral from your primary care physician.

Thank you for being prepared for your first visit. We encourage bringing a written list of questions or concerns to your appointment. If you have any additional questions please call the office at 425-394-1200.

Sincerely,

Doctors and Staff of Rehabilitation Options of Issaquah

Specializing in back and neck pain, sports medicine, and joint injuries

Rehabilitation Options of Issaquah Intake Form

Name _____	Date of birth _____
Address _____	Social Security # _____
_____	Marital Status _____
City, State, Zip _____	Referring Physician _____
Phone _____	Primary Physician _____
Phone _____	Email address _____

Patient's Employment Info	Emergency Contact
Employer _____	Name _____
Phone _____	Phone _____
	Relation _____

Responsible Party Information if different than the patient	
Name _____	Employer _____
Address _____	Phone _____
_____	SS # _____
City, State, Zip _____	Date of birth _____

DUE TO INCREASING INSURANCE FRAUD YOUR INSURANCE COMPANY NOW REQUIRES YOU HAND WRITE IN THE BELOW INFO. EVEN WITH COPY OF CARD.

Primary Insurance Information	Secondary Insurance Information
Copay amount _____	Copay amount _____
Subscriber Name _____	Subscriber Name _____
Subscriber Phone # _____	Subscriber Phone _____
Subscriber Employer _____	Subscriber Employer _____
Insurance Company _____	Insurance Company _____
Subscriber Social Sec # _____	Subscriber Social Sec # _____
Subscriber Date of birth _____	Subscriber Date of birth _____
Policy Number _____	Policy Number _____
Group Number _____	Group Number _____
Relation to Patient _____	Relation to Patient _____

Circle if this auto accident related: Yes or No. (If yes ask receptionist for separate form)

Circle if Work Related: Yes or No

Claim Number _____	Body Part Injured _____
Claim Manager name _____	Claim Manager phone _____
Date of Injury _____	Insurance Company _____
Address _____	Insurance phone _____

If work related-Is employer listed above where you worked at time of injury? Yes or No

Insurance Authorization and Assignment

I attest that the information I have given is correct and true to the best of my knowledge to Rehabilitation Options of Issaquah and authorize them to furnish information regarding my illness to my insurance company. I understand that I am responsible for any amount not paid for by my insurance.

Patient/Guardian Signature _____
Date

Rehabilitation Options of Issaquah

Financial Policy

Dear Patient,

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered and non-covered, medically necessary services rendered. We will bill, both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of your co payment. There is a \$25.00 billing fee for each missed co pay.

If we do not receive payment from your primary carrier for any reason, within 60 days of filing, you are responsible the entire amount. Payment is due 10 days after receipt of the statement. (We will bill your secondary only after your primary has responded.)

2. For patients who have insurance coverage with an insurance carrier whom we are not contracted with, please note:

We will bill your primary and secondary insurance. If we do not receive payment from your primary insurance within 60 days of filing, you will be billed the entire balance and payment is due 10 days after the receipt of the statement. (We will bill your secondary only after your primary has responded.)

Any amount not paid by your insurance(s) will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

3. For patients with auto related injuries please note the following:

We will bill your Personal Injury Protection (PIP) insurance through YOUR automobile insurance for an auto related injury. We must have the claim number and the address to send the billing to before you are seen by the doctor. We will bill your auto insurance weekly for you, and you will receive a statement from our office each month. The full balance is your responsibility in full over 60 days. We do not bill third parties (i.e. the liable party).

4. For patients with a workers compensation claim: if your claim is denied, the patient is responsible to provide us with current health care insurance information or pay the balance in full.
5. Please be aware that some, and perhaps all, services provided may be considered as not being reasonable and necessary under your medical plan benefits. You are responsible for payment regardless of any insurance company's determination. This pertains to ALL insurances (motor vehicle included.)
6. We will always do our best to accommodate your schedule. An extra charge may be applied for any emergency or "work in" appointments. If any other patients are inconvenienced by "squeezing you in" this fee may apply.
7. Extra forms required by the patient to be filled out by the patient, such as disability forms, letters to employers and insurers, etc that require additional time or research may incur an additional charge to the patient. Extensive forms and/or records review may be billed at an hourly rate, otherwise, a standard fee may apply.
8. **If you need to cancel an appointment we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. There will be a \$50.00 no-show fee for any appointments not cancelled at least 24 hours prior to the scheduled appointment time. This fee will not be paid by private insurance, L&I, or PIP coverage. This fee is for all departments at ROI. All no show fees must be paid in full before next appointment is scheduled.**

Your signature below signifies that you have read, and understand your responsibility regarding charges incurred in this office.

Patient's (or guardian's) name printed

Patient's (or guardian's) signature

(11/2/2010)

Rehabilitation Options of Issaquah

Medication Policy

1. **Refills requests must be made 72 hours in advance for all medication.**
2. Pain medications cannot be refilled on weekends, Friday night, Sat-Sunday. Please check your prescription carefully. Check your medications on Wednesday to be sure you have sufficient supply.
3. Medication prescriptions are provided to last until your next appointment. Requests to changes medications or dosing between appointments should be unusual. While we understand that problems occur, patients who call the office excessively for issues with medications in between appointments may be limited to prescriptions changes only at their appointment time.
4. Urgent medication or medical issues can be discussed by calling the on-call number and non-pain medication refills may be prescribed as needed. Patients, who abuse this privilege, may be limited as in #3 above.
5. Requests or new medications or changes in dosages must be discussed while seeing physician. The office staff cannot discuss new medications or change requests after your appointment is complete
6. Patients receiving pain medication and who need to be seen in the ER or another physician in an urgent basis must notify the other physicians of their relationship with Rehab Options of Issaquah.
7. I understand that physicians cannot write me prescriptions out of state.
8. I understand I will not get a replacement prescription if mine is lost or stolen.
9. I understand that for my protection, medications will not be refilled early.
10. I will get all of my medication from one pharmacy.
11. **Prescriptions will not be filled early. Take medication as directed.**

Patient name printed

Patient signature

Date

Please let us know which pharmacy you would prefer your prescriptions be sent to.

Pharmacy Name

Pharmacy Address

Pharmacy Phone number

Pharmacy Fax number

Primary Care Physician Name-_____

Address

Phone number

Fax number

Do you want us to send a copy of your chart notes to your PCP? _____



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Patient Name

Date

Specializing in back and neck pain, sports medicine, and joint injuries



REHABILITATION
OPTIONS *of* ISSAQUAH

To provide the best medical care, and for the safety of your children, and privacy of other patients, ROI does not permit children to accompany parents to medical or physical therapy appointments. Children under the age of 12 cannot be left unattended in the lobby. If you do not have available childcare we would be happy to reschedule your appointment.

Thanks,

ROI Staff

Patient Signature

Date

Name: _____

Date: _____



REHABILITATION
OPTIONS of ISSAQUAH

History of Present Condition

Name: _____

Date: _____

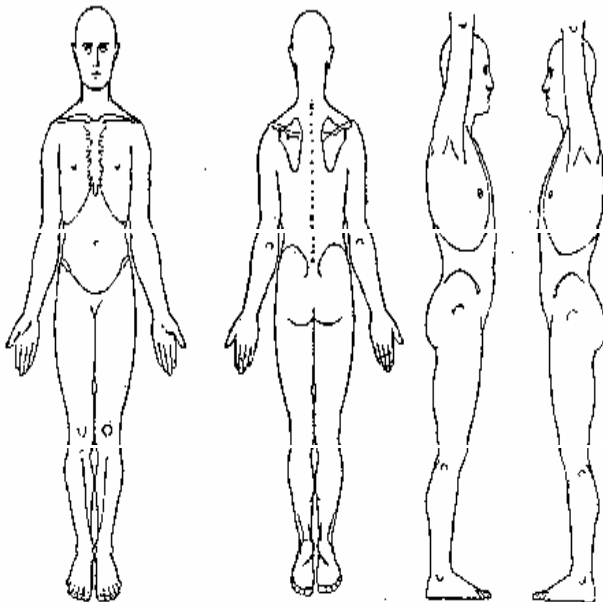
1. What are your symptoms?

2. When did your symptoms begin?

(Indicate a specific date if possible) _____

Locate areas of pain or abnormal sensation on the body chart below (Shade where appropriate)

Right Left



3. Was the onset of this episode **gradual** or **sudden**? (Circle ONE)

4. Which of the following best describes how your injury occurred?

- Lifting
- Car Accident (MVA)
- Incident at Work
- Fall
- Overuse
- Trauma
- Degenerative Process
- During recreation/Sports
- Throwing
- Unknown

Other _____

5. Since onset are your symptoms getting:

- Better Worse Not Changing

6. Have you had similar symptoms in the past?

- YES NO

More than 1 episode? Yes No

7. Nature of pain/symptoms (check all that apply)

- sharp aching occasional
 dull periodic other _____
 throbbing constant

8. As the day progresses, do your symptoms:

- increase decrease stay the same

9. Does the pain wake you at night? No Yes

If "yes" is it present:

- while lying still
 only when changing positions
 both

10. Do you have pain/stiffness upon getting out of bed in the morning? Yes No

11. In what position do you sleep (check all that apply)

- right side left Side
 back chair/recliner
 stomach Back/side/stomach
 other _____

12. Since the onset of your symptoms have you had

difficulty with control of bowel or bladder Function

- fever/chills
 numbness of _____
 dizziness or fainting attacks
 weakness
 unexplained weight change
 night pain/sweats
 malaise
 problems with vision or hearing



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Name: _____

Date: _____

13. What relieves your symptoms?

(check all that apply)

- sitting standing massage
- heat exercise medication
- cold walking stretching
- rest lying down wearing a splint
- other _____
- Nothing relieves my symptoms

14. What aggravates your symptoms?

(Check all that apply)

- sitting
- standing
- squatting
- coughing/sneezing
- taking a deep breath
- going to/rising from sitting
- lying down
- walking
- up/down stairs
- reaching overhead
- reaching in front of body
- reaching behind back
- reaching across body
- looking up overhead
- sustained bending
- stress
- recreation/sports including _____
- other _____

Please List any recent/relevant past surgeries related to your current problem:

Surgery	Date
_____	_____
_____	_____

FOR

Family History

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

- Diabetes
- High blood pressure
- Stroke
- Thyroid problems
- Psychological Condition
- Cancer (type) _____
- Osteoporosis
- Arthritis
- Other _____

Medications

Please list any prescription medications you are currently taking (pain pills, injections/patches, etc):

Prescribing MD: _____

Phone # _____

Are you currently taking any of the following over the counter medication?

- aspirin
- Tylenol
- antihistamines
- Advil/Motrin/Ibuprofen
- corticosteroids
- vitamins/mineral supplements
- other _____

Past Medical History

Do you now or have you ever had: (check if "yes")

- | | |
|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke/Vascular |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis/Rheumatoid Arthritis | <input type="checkbox"/> Epilepsy (seizures) |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stomach problems | |
| <input type="checkbox"/> Lung Problems | |



REHABILITATION
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Name: _____

Date: _____

Do you have any allergies to medication? Yes or No

If yes please list:

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Thanks,

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Patient Signature

Date