

Paragon Fitness & Physical Therapy, P.S.
2921 East Madison., Suite 2, Seattle, WA 98112. 206-527-3480 FX: 206- 729-0599

Patient Registration – Please Type or Print

PATIENT _____ DATE _____

Last name First name Middle Initial

ADDRESS _____

EMAIL _____ MARITAL STATUS Single Married Other

PHONE (w/area code) _____ Work _____ Cell _____

BIRTHDATE _____ SEX Male Female

SOCIAL SECURITY # _____

DRIVER'S LICENSE# _____

EMPLOYED FULL-TIME STUDENT PART TIME STUDENT

EMPLOYER/SCHOOL NAME _____

EMPLOYER'S ADDRESS _____

EMERGENCY CONTACT _____

Phone Number _____

INSURANCE INFORMATION – PLEASE PROVIDE YOUR CARDS FOR COPYING

NAME OF INSURED _____

BIRTHDATE _____

(Subscriber Name) Last name First name Middle initial _____

Sex Male Female

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD DEPENDENT

INSURED'S ADDRESS _____

EMPLOYER _____

PRIMARY INSURANCE _____

ID Number _____ Group Number _____

SECONDARY INSURANCE _____

INSURED'S NAME _____ BIRTHDATE _____

ID NUMBER _____

GROUP NUMBER _____

IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT AUTO ACCIDENT OTHER

DATE OF CURRENT: ILLNESS INJURY:

MONTH _____ DAY _____ YEAR _____

NAME OF REFERRING PROVIDER (M.D., NATUROPATH, CHIROPRACTOR, ETC.) _____

ADDRESS: _____

Street City State Zip Phone Number Fax

**IF THIS IS AN L&I 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 (w/area code) _____

CLAIM # _____

We realize that completion of this form is an added burden to you as a consumer, and 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.

Please note 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 PARAGON FITNESS & PHYSICAL THERPAY, P.S.

• I am financially responsible for any balance due.

Signed _____ **Date** _____

BILLING AND PAYMENT POLICY

Welcome to PARAGON FITNESS & PHYSICAL THERAPY. In order to budget for your physical therapy services, we would like to provide you with a brief explanation of our payment policy.

For the best chance of reimbursement from your insurance carrier:

• We suggest that you contact your insurance company prior to your first appointment to determine your physical therapy coverage and providership stipulations. Coverage depends upon your insurance company and the specific plan you have chosen. We have enclosed a **Billing Information Request Form** to assist you in determining your coverage.

• You will need a current doctor's prescription for physical therapy services in order to submit your claim. Referrals are current for 90 days unless otherwise specified.

To assist you in your budget planning:

- The initial evaluation lasts one hour and includes a written report to your referring provider. We are providers for most major insurance companies. Please refer to your individual insurance company for information regarding your physical therapy benefit coverage. Our Billing Information Request Form can assist you in obtaining the most pertinent information from your insurance company's customer service representative.
- Subsequent visits are based on your specific time needs with the physical therapist and the specific procedures performed. All treatments are one to one with the physical therapist.

Note: Fees fluctuate depending on the procedure performed.

Payment plans are available upon request. Please contact the Mike Rogers for terms of a payment plan. **Co-pays are due at the time of service.**

I understand my financial responsibilities as described above.

Signature _____ Date _____

BILLING INFORMATION REQUEST FORM

In order to fully understand physical therapy coverage under your insurance plan, we have developed this questionnaire 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 (w/area code) _____
- 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 **PARAGON FITNESS & PHYSICAL THERAPY** for payment of services? YES/NO
OR, IS A PRESCRIPTION REQUIRED?
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 a provider for the plan, what is the benefit coverage for Paragon Fitness & Physical Therapy, P.S.? (i.e., 60%, 80%, etc.).

CANCELLATION POLICY

Patients are seen at Paragon Fitness & Physical Therapy, P.S. by appointment only. Scheduling is based on a first come, first served basis. In the event you need to cancel an appointment, we request at least **24 business hours notice**.

Your appointment time is very important to us. If we do not get at least 24 business hours notice of your cancellation, we may not be able to schedule another patient who may need that time slot. This is detrimental to us and to the patients we try to serve.

Unfortunately, we have experienced patients canceling at the last minute or not showing for appointments. Therefore, we have found it necessary to institute a **\$65 cancellation fee** for patients who fail to provide **24 business hours** advance notice.

Repeated late cancellations or no shows indicate a lack of commitment to your health care. As a result, 2 or more late cancellations or no shows will result in **discontinuing** physical therapy. In that event, your referring provider and/or claim manager will be notified of the reason for discontinuation of physical therapy.

Late cancellation due to illness or family emergency is **excluded** from this policy.

Arriving on time for your appointment is also critical to the optimal delivery of care.

Chronic late arrivals indicate a lack of commitment to your health care. Arriving more than 7 minutes late for 2 or more visits may result in **discontinuing** physical therapy. In that event, your referring provider and/or claim manager will be notified of the reason for discontinuation of physical therapy. Reading and signing of this policy states you understand the policy and all late cancels and no shows not excluded from this policy will be charged.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

Signature _____ Date_____

Use and Disclosure of Your Protected Health Information Without Your Authorization

Here are some examples of how we may use and disclose protected health information without your authorization.

Treatment. We use and disclose your health information to provide treatment. For example:

- Your physician may use your information to determine whether specific diagnostic tests, therapies, and medications should be ordered.
- Physical Therapists or students may need to know and/or discuss your health problems to carry out treatment and to understand how to evaluate your response to treatment.
- We may disclose your health information to another one of your treatment providers in the community, unless the provider is not currently providing treatment to you and you direct us in writing not to make the disclosure.

Payment. We may use your health information for payment purposes. For example:

- We may use your information to prepare claims for payment for services.
- If you have health insurance and we bill your insurance directly, we will have to include information that identifies you, as well as your diagnosis and procedures so that we can be compensated for the treatment provided. However, we will not disclose your health information to a third-party payor without your authorization except when allowed by law.

Health Care Operations. We may use and disclose your health information to carry out health care operations. For example, we use and disclose health information from patients to monitor and improve our services. Also, authorized staff may look at portions of your record to perform administrative activities.

Train Staff and Students. We may use and disclose your information to teach and train staff and students. One example of this is when teaching physical therapists review patient health information with physical therapy students.

Contact You for Information. Your health information may also be used to contact you (for example, by calling you or sending you a letter) to remind you about appointments or advise you about other services provided at Paragon Fitness & Physical Therapy.

Use and Disclosure When You Have the Opportunity to Object

Facility Directory. Unless you object, you will be included in our Facility Directory. This information is limited to your name, address, email address, and phone number. This directory is used to notify you of new services provided or to send you greetings, or make reminder calls.

Disclosure to and Notification of Family, Friends, or Others. Unless you object, your health care provider will use his or her professional judgment to provide relevant protected health information to your family member, friend, or another person that you indicate has an active interest in your care or the payment for your health care.

Use and Disclosure that Requires Your Authorization

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. If you provide us with written authorization, you may revoke that authorization at any time unless disclosure is required for us to obtain payment for services already provided, we have otherwise relied on the authorization or the law prohibits revocation.

Your Individual Rights Regarding Patient Health Information

You have specific individual rights as to the use and disclosure of your protected health information.

Contact us regarding your health information at:

2921 East Madison STE 2, Seattle WA 98112

Your specific rights are listed below:

- **The right to request restricted use:** You may request in writing that we not use or

disclose your information for treatment, payment, and/or operational activities except when specifically authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. If you make your request to Paragon Fitness & Physical Therapy P.S., Paragon Fitness & Physical Therapy P.S will provide you with written notice of its decision regarding your request.

- **The right to receive confidential communications:** You have the right to request that we communicate with you about health matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **The right to inspect and receive copies:** In most cases, you have the right to look at or order a copy of your health information.

- **The right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we correct the existing information or add the missing information. In your request for the amendment, you must give a reason for the amendment. We are not required to amend your record, but a copy of your request will be added to your record if you direct us to file it.

- **The right to know about disclosures:** You have the right to receive a list of instances when we have disclosed your health information except in certain instances, such as disclosures for treatment, payment, or health care operations or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Each additional request within the same calendar year will require a processing fee.

- **The right to make complaints:** If you are concerned that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint with the Paragon Fitness & Physical Therapy P.S

If you believe that your privacy rights have been violated, you may also contact the U.S. Department of Health and Human Services • Office for Civil Rights:

Office for Civil Rights

U.S. Department of Health & Human Services

2201 Sixth Avenue - Mail Stop RX-11

Seattle, WA 98121

(206) 615-2290; (206) 615-2296 (TDD)

(206) 615-2297 FAX

Privacy Notice Changes

Our Legal Duty: We are required by law to protect the privacy of your information, to provide this Notice about our

privacy practices, and to follow the privacy practices that are described in this Notice.

We reserve the right to change the privacy practices described in this Notice. We reserve the to make the revised or changed Notice effective for protected health information we already have as well as any information we may receive in the future. You may request a copy of the current Notice in effect from our office.