NORTHWEST THERAPY CENTER

PATIENT REGISTRATION FORM

Welcome to our center. In order to serve you properly, we will need the following information. **(PLEASE PRINT)**

Patient's Name	**Sex** M ☐ F ☐	**Birth Date** **Age** ________	**Marital Status** Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence address **City**	**State** **Zip**	**Home Phone**	**Patient's Social Security#**
Person financially responsible for this account Self ☐ Spouse ☐		**Responsible Party's Birth Date**	**Responsible Party's Social Security#**
Person to contact in case of emergency:	**Phone number**	**Relationship to patient**	
ARE YOU CURRENTLY EMPLOYEED Y ☐ N ☐ If no proceed to next section	**Occupation**		**How long at the current employer?**
Name of Employer **Address**			**Business Phone Number**
Referred by: (include address and phone number)			

MEDICARE and INSURANCE INFORMATION

Medicare YES ☐ NO ☐	**Medicare Number:**		**Effective Date**
Primary Insurance Number	**Address**	**Policy#** **Group#**	**Effective Date**
Secondary Insurance Number	**Address**	**Policy#** **Group#**	**Effective Date**
Subscriber's Name	**Address**		**Phone Number**
Subscriber's Date of Birth: **Subscriber's Social Security Number:**		**Relationship to patient**	
☐ **Personal Injury Accident** ☐ **Worker's Compensation**	**Date of Accident** **Claim number**	**Carrier's name and address**	**Carrier's phone number** **Authorization number**
Attorney's Name	**Phone number**	**Address**	

Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patients Rights and Responsibilities and this facility's Grievance Procedure.

______________________________ Patient's signature ______________________________ Date

______________________________ Patient's Parent, Guardian's Signature (if child is under 18 years old) ______________________________ Date

Patient Consent Form
Notice of Privacy Practices

Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make the Notice available to you.

When you sign and date this form you are agreeing that you were given a copy of this notice.

The notice states that we may use and disclose protected health information about you for your treatment, payment, and health care operations. In your notice, there is a complete list of examples of how we may use to disclose your personal health information without specific authorization from you.

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No	
Leave a message with someone at home? With whom:____________	Yes	No	
Leave a message at your place of work?	Yes	No	N/A

Other than your doctor, please list full name and relationship
of individual with whom we may discuss your medical condition:

____

Patient Name: ______________________________________

Patient/patient representative Signature:

______________________________ ______________________________

Signature Date

Summary of Patient's Rights and Responsibilities

We are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and responsibilities.

You have the *RIGHT:*

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling
- To consent to, or refuse, any care of treatment
- To select and or change your health care provider
- To review your medical records
- To information about services and any related costs

You also have the *RESPONSIBILITY*

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms or failure to improve\to respect clinic policies
- To keep appointments or cancel I advance\to seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

______________________________ Signature

______________________________ Date

Patient Name: ______________________________

MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

PLEASE TELL US ABOUT YOUR SYMPTOMS

Age: ______________

Do you get short of breath? ☐ Yes ☐ No

Activities that cause the shortness of breath:

☐ Walking
☐ Climbing Stairs
☐ Lying Down
☐ Cooking
☐ Dressing
☐ Gardening
☐ Exercising
☐ Carrying thing such as Groceries, laundry
☐ Talking
☐ Cleaning
☐ Personal Hygiene
☐ Other: ______________________________

Does your current breathing problem affect your mood? ☐ Yes ☐ No

Are you currently having Physical Therapy anywhere? ☐ Yes ☐ No

Are you currently getting Home Health Services? Does a nurse come to your house? ☐ Yes ☐ No

Do you have Pain or weakness in you?

Neck _ Back_ Upper Extremities (shoulders, wrists) _ Lower Extremities (hips/legs) _

Current Living Environment:

Do you live: ☐ Alone; ☐ With Spouse; ☐ With Family Member; ☐ With Friend

Living in a ☐single level home; ☐double or-tri-level home; ☐Apartment; ☐ Assisted Living

Do you have stairs in your home; ☐ yes (how many) ____________ ☐ No

Who does the cooking, cleaning, laundry and shopping in your home: ____________________

Employment: full-time ______ part-time_____ retired _____disabled_____ Occupation:____________________

Smoking History: ☐ Yes ☐ No (If yes, when did you quit?______________________________)

Do you use Oxygen? ☐ Yes ☐ No Liter: _______ Name of Oxygen Provider:____________________

☐ All the time
☐ At home only
☐ As needed
☐ At night only

Have you been hospitalized in the past year? ☐ No ☐ Yes

(If yes, please describe including approximated dates, location and reason for hospitalization)

____

____

Are you now taking any medications including non-prescription medication? Please list below.

____

____

____

Patient Name: ______________________________

(Please continue on page 2)

Medical History form page 2

Do you have, or have you had, any of the following diseases or problems?

SYMPTOM REVIEW

Gastrointestinal

- ☐ Poor appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Nausea or vomiting
- ☐ Rectal bleeding or blood in stools
- ☐ History of liver disease or abnormal liver tests

Cardiovascular

- ☐ Chest pain
- ☐ History of angina or heart attack
- ☐ History of high blood pressure
- ☐ History of irregular beat
- ☐ History of poor circulation

Pulmonary/lungs

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Asthma or wheezing

Muscle/joint/bone

- ☐ Swelling of ankles or legs

pain, weakness or numbness in

- ☐ Arms or hands
- ☐ Back or hips
- ☐ Legs or feet
- ☐ Neck or shoulders

Neurologic

- ☐ History of stroke
- ☐ Blackouts or loss of consciousness

General

- ☐ Weight gain/loss of 10+lbs. during last 6 months
- ☐ Poor sleep
- ☐ Fever
- ☐ Headache
- ☐ Depression/Anxiety/Nervousness
- ☐ Allergies or adverse drug reactions (describe)

Eyes, ears, nose, throat

- ☐ Blurred vision
- ☐ Other change in vision
- ☐ History of glaucoma or cataracts
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness

Genitourinary

- ☐ Frequent or painful urination
- ☐ Blood in urine

Skin

- ☐ Itching
- ☐ Easy bruising
- ☐ Change in moles

Endocrine

- ☐ History of diabetes
- ☐ History of thyroid disease
- ☐ Change in tolerance to hot or cold weather
- ☐ Excessive thirst

Women only

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods

Date of last mammogram:

Men only

- ☐ PSA

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When? _______________

Please describe any "yes" answers to the above questions:____

____

Anything else?

- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

(Please continue on page 3)

NORTHWEST THERAPY CENTER

List goals or activities you would like to be able to do after completing therapy: ____________________

____

____

PSYCHOSOCIAL SERVICES:

Northwest Therapy Center offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

☐ Yes If YES, please write reason for evaluation:____________________

☐ No If NO, please sign below:

I am aware of an LCSW on staff and psychosocial services at West Coast. At this point I do not require a psychosocial evaluation.

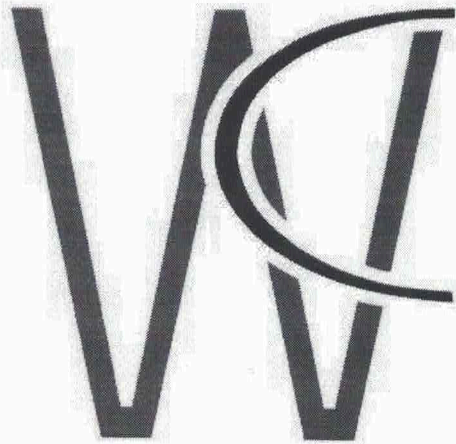
____

Patient's Signature (or individual completing this form for patient)

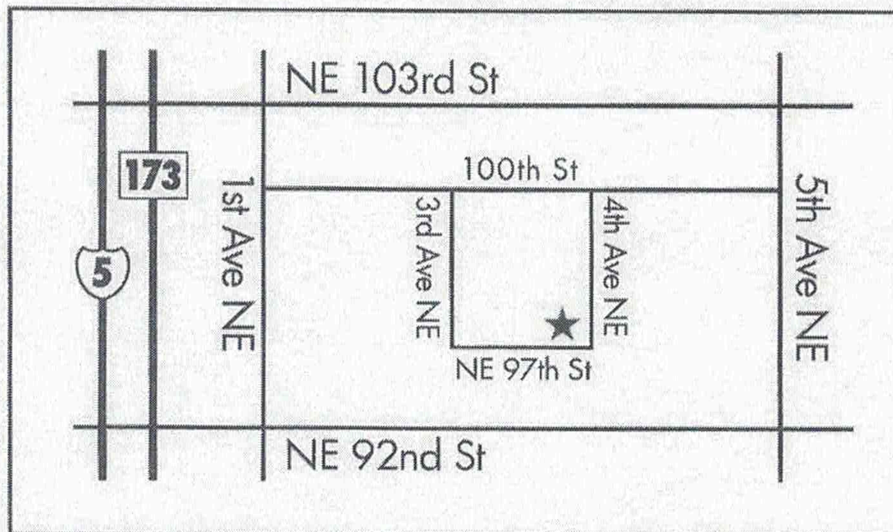
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERD TO MY SATISFACTION. I WILL NOT HOLD THE PROGRAM OR ANY OF ITS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THE FORM.

____ ____________________

Patient's Signature (or individual completing this form for patient) Date



NORTHWEST THERAPY CENTER
320 NE 97TH STREET, SUITE B
SEATTLE, WA 98115
PHONE: 206-525-1010
FAX: 206-523-1330
northwesttherapycenter@gmail.com
www.westcoastcorfs.com



Driving Directions:

From I-5 North

Take the 1ST AVE NE exit, EXIT 173, toward NORTHGATE WAY.
Turn RIGHT onto 1ST AVE NE.
Turn LEFT onto NE 100TH ST.
Turn RIGHT onto 3RD AVE NE.
Turn LEFT onto NE 97TH ST.
320 NE 97TH ST is on the LEFT.

From I-5 South

Take the NORTHGATE WAY exit, EXIT 173, toward 1ST AVE NE.
Take the ramp toward NORTHGATE WAY/1ST AVE NE.
Turn SLIGHT RIGHT onto CORLISS AVE N.
Turn SLIGHT RIGHT onto N NORTHGATE WAY
Turn SLIGHT RIGHT toward I-5 N/VANCOUVER BC.
Turn SLIGHT RIGHT onto 1ST AVE NE.
Turn LEFT onto NE 100TH ST.
Turn RIGHT onto 3RD AVE NE.
Turn LEFT onto NE 97TH ST.
320 NE 97TH ST is on the LEFT.