Pine Lake Physical Therapy
& SPORTS REHAB. P.S.

2850 228th Avenue S.E.◦ Suite B ◦ Sammamish, WA 98075
Phone: 425-391-4488 Fax: 425-391-8287
www.pinelakept.com

TODAY'S DATE: ___/___/_____

PATIENT LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

MAILING ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS *(Bills are sent out via Email**)*_____@_____**

HOME PHONE: (_____)_____-_____

CELL PHONE: (_____)_____-_____

PLEASE CHECK HOW YOU WOULD PREFER APPOINTMENT REMINDERS

□EMAIL □TEXT MESSAGE □PHONE CALL □NO REMINDERS PLEASE

SOCIAL SECURITY # _____ AGE_____ DATE OF BIRTH___/___/_____ (MALE OR FEMALE)

REFERRING PHYSICIAN:_____ PRACTICING LOCATION:_____

DATE OF MOST RECENT PHYSICIAN VISIT: ___/___/_____

PRIMARY CARE PHYSICIAN:_____

CAUSE OF INJURY_____ DATE: ___/___/_____

LOCATION OF INJURY

UPPER EXTREMITY LOWER EXTREMITY NECK/MID-BACK LOWER BACK

WAS THE INJURTY CAUSED BY AN ACCIDENT WHICH WAS NO FAULT OF THE PATIENTS? (YES/NO)

IF YES: NO ACCIDENT AUTO ACCIDENT WORK RELATED ACCIDENT OTHER

CLAIM #_____ COMPANY OR AGENCY: _____

So we can continue to provide quality care to you and our patients in their recovery,

we ask *24 hours' notice* for cancellation. Thank you!

AUTHORIZATIONS

✓ I hereby give my consent to Pine Lake Physical Therapy & Sports Rehab, P.S. to provide Physical Therapy services on an ongoing basis as prescribed by my Physician.

✓ This authorization or its photocopy will authorize the release and receipt of any medical information necessary for treatment and/or to process claims for services rendered by this provider.

✓ I authorize the Physical Therapist and Staff to provide services as outlined under the state and federal laws and regulations.

✓ I understand that the Physical Therapist may contact the other medical care providers to communicate information regarding this service.

✓ Should I choose as a patient of PLPT to have my minor children accompany me to any appointment I release PLPT Staff from any responsibility for the health and welfare of said child during my treatment at their facility.

✓ Services may be discontinued at anytime I so choose. My rights include, but are not limited to RCW 70.127.140. Any grievance should be addressed to Ron D. Enyeart or Cynthia A. Enyeart @425-391-4488, fax 425-391-8287 or by mail at: 2850 228th Ave. SE Suite B Sammamish, WA 98075.

✓ I understand that I am responsible for all charges incurred for services rendered and Pine Lake Physical Therapy & Sports Rehab, P. S. cannot guarantee benefits provided by my health care insurance.

✓ I request and authorize my insurance company and/or Medicare/Medicaid to make payments of authorized benefits on my behalf to Pine Lake Physical Therapy & Sports Rehab, P.S. My responsibility and insurance coverage for copayment has been explained to me.

✓ I have read the **Notice of Privacy Practices** that addresses all procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of my **Health Information**.

Patient or Responsible Party _____ Signature Date Signed _____

****We sincerely appreciate you choosing Pine Lake Physical Therapy for your rehabilitation needs. Is there a friend or family member we can thank for pointing you in our direction?****

Name:_____