Lake Washington PHYSICAL THERAPY

Orthotic Case Information

(Please Fill Out Forms Completely & Print)

(IF PATIENT IS UNDER 18 YEARS OF AGE LEGAL GUARDIAN MUST SIGN ALL PAPERWORK)

Patient Name:

(Last)_____ , (First) _____ (Middle Initial)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Mobile Phone :_____

Work Phone: _____ Email Address: _____

Date of Birth: _____ /_____ /_____ **SS#:** _____-_____-_____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ M ☐ S ☐ D ☐ W

Emergency Contact:

(Last)_____ , (First) _____

Relationship: _____Phone: _____

Employment Status: ☐ Student ☐ Working ☐ Retired ☐ Homemaker ☐ Unemployed

Employer: _____ Type of work: _____

Problem (Injured Region(s) of Body): _____

Date of Injury: ____/____/_____ (**Required:** Date is mandatory to trigger your insurance coverage)

Referring Physician: _____ Date of Physician visit: _____

Primary Care Physician:_____

Condition Related To: ☐ Employment ☐ Auto Accident ☐ Other Injury _____

Attorney: Yes ☐ No ☐ Attorney Contact: _____

How did you find Lake Washington Physical Therapy: ☐ Doctor ☐ Friend ☐ Family ☐ Yelp ☐ Google

☐ Facebook ☐ Former Patient ☐ Lecture ☐ Walk by ☐ Other_____

Patient / Guardian Signature: _____**Date:**_____

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Current Orthotic Policy: (Beginning February 2022)

- Our front office and team of therapists will do our best to have your device created and delivered in a timely manner
    - A casting appointment is scheduled through our front office
    - Your foot will be scanned via a ProLab 3-D Scanner by a licensed therapist
    - The file is then emailed to the fabrication lab in Santa Rosa, CA that day
    - The lab begins work on your custom device after receiving the 3-D scan file and faxed paperwork from our therapist
    - We pay the shipping and handling as part of the device cost for new orthotics
        - If you need to send molds, shoes, or old orthotics back to the lab, the lab address will be provided for you and this is the patient's responsibility for both sending and retrieving them.
    - We put a "**rush**" on every first pair of orthotics for the lab and pay the difference for you.
        - Fabrication typically is completed in 7-10 business days
    - A "Fitting" appointment is booked for 2 weeks after the casting
        - Due to the large amount of insurance companies that reject orthotic claims we **Do Not Submit Orthotics without a Payment Deposit**. We then will submit the claim to insurance any overpayment will be refunded to the patient at the completion of care and the insurance adjustments.
        - **This must be paid prior to device fabrication by the lab.
    - Our front office will do our best to verify benefits prior to your evaluation/casting visit but even verbal, online, or written approval from your insurance is <u>no guarantee</u> of payment for the visit or devices.
    - Upon the delivery of the orthotic device to LWPT we will call to notify you and make sure you have a fitting appointment.
        - During the fitting appointment:
            - The therapist will walk you through the process of breaking in the orthotics
            - Any trimming, grinding, or additional posting will be done
            - A review shoe education when picking out shoes with the orthotic

- LWPT bills patient's insurance when possible for the fitting/casting (2 appointments) in accordance with their outlined insurance benefits:
    - We provide one of the most economical custom orthotics in the state of Washington
    - For simplicity LWPT charges one price for all types of orthotics
    - LWPT is billed by the orthotic lab the moment the scans and paperwork are sent and **no custom device can be sent back for a refund** unless the materials fail within 30 days of FedEx delivery.
        - Private Pay 1st Pair (calendar year): $400+tax (device / rush delivery)
        - Private Pay 2nd Pair (calendar year): $375+tax (device/standard delivery)
        - Private Pay 3rd Pair (calendar year): $325+tax (device/standard delivery)

Disclaimer:

- There is no satisfaction guarantee, but we will provide a window of up to 30 days from the time of the first fitting and work with you for adjustments in accordance with your insurance plan.
    - If you had to private pay for the device or have no insurance the therapist will do their best to set aside time to accommodate your requests and/or complaints for 30 days.
    - If you had previously billed insurance for the visit or the device the therapist will require that you make the adjustments part of your ongoing therapy visits or that you set up a separate appointment for modifications.

I understand the following:

- My orthotics will likely take 7-10+ business days to arrive
- LWPT will be emailing my custom 3-D foot scan to ProLab Orthotics Inc.
- In order to bill insurance: I **must pay a deposit** in the case of insurance rejections for the associated visit(s) or device.
- There is <u>not</u> a 100% satisfaction guarantee, but there are 30days from the time of the initial fitting that the therapist will make adjustments to the device

Name:

_____

Signature: _____ Date: _____

Verified Payment Taken by: Credit Card #: _____

Date of Payment: _____ Exp:_____ Code: _____

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Medical History

Past	Current		Region & Date
☐	☐ Physical Therapy	☐	Acupuncture _____
☐	☐ Ergonomics Evaluation	☐	CT Scan _____
☐	☐ Chiropractic	☐	MRI _____
☐	☐ Emergency Room Care	☐	Bone Scan _____
☐	☐ Massage Therapy	☐	X-Rays _____

Please list any surgeries/procedures you have had for this injury: _____
Days a week do you perform physical activity? _____
Are you aware of your diagnosis and prognosis as explained by your doctor? ☐ Yes ☐ No
Please list any current medications (prescribed and over the counter):

_____

Please list any other information that you believe would assist the therapist in your care:
_____

What are your rehabilitation expectations and goals in this program other than pain relief?
_____

Patient / Guardian Signature: _____Date:_____

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Consent for Treatment

I agree to give my consent for *Lake Washington Physical Therapy, LLC.* to furnish rehabilitation services considered necessary and proper in the treatment for my physical condition.

Name of Patient: _____
(Please print complete name)

Authorization for Disclosure of Medical Records

I authorize *Lake Washington Physical Therapy, LLC.* to release copies of the physical therapy record and billing statements to my insurance company for the purpose of billing for the services rendered.

eMail Privacy Statement

Lake Washington Physical Therapy's Therapists like to stay in close contact with patients. We will be using secure email at times during your treatment to send pertinent information regarding your account, recovery, and progress. Our office is committed to your privacy and will not sell, disseminate, or give your email address to 3rd parties.

Information Privacy Statement

Lake Washington Physical Therapy, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution upon request. The undersigned acknowledges receipt of this information.

I understand and agree to *Consent for Treatment*, *Authorization for Disclosure of Medical Records*, *and the Information Privacy Statement* above:

Patient/ Guardian _____ **Date:** ___/___/___

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Financial Policy Statement

Lake Washington Physical Therapy, LLC will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance per your insurance contract.
Co-Pays are always due at the time of service as described in your insurance policy.

Billing Policy for Lake Washington Physical Therapy

If we are billing your insurance company please contact your insurance company for information regarding your physical therapy benefits. As a courtesy our office staff will verify insurance coverage, but this is not a guarantee. It is the patient's responsibility to confirm benefits with their insurance company prior to the first physical therapy appointment. *(Ask our front office if you have questions).*

Balances owed to Lake Washington Physical Therapy

- Balances unpaid after 30 days will accrue a $35.00 fee each billing cycle.
- Balances unpaid after 60 days must have payment arrangements with our billing office.
- Balances unpaid after 91 days will be turned over to our collection agency.

*Checks returned with non-sufficient funds will be charged a $35.00 fee.

Lake Washington Physical Therapy Cancellation/ No-Show Policy

- Lake Washington Physical Therapy appointments scheduled represent time set aside specifically for you as a patient. All cancellations must be made at least **24 hours** prior to the scheduled visit. Patients who cancel or No-show on three separate occasions will be allowed to schedule additional appointments only at the discretion of the primary physical therapist.

- By law, all cancellations, and No-shows involving Worker's Compensation claims must be reported to your physician and your claims adjuster.

- **All Cancellations (less than 24 hour notice) and No-show appointments will be charged a fee of $30.00 to your account. This fee is due before or at the time of your next physical therapy visit. (charges removed from your account balance by bringing in 4 cans of food per missed appointment)**

I understand that my insurance company does not guarantee payment and I am financially responsible for all charges incurred with *Lake Washington Physical Therapy, LLC*. I understand and agree to the financial policy statement, billing policy statement, and cancellation policy.

Patient/ Guardian _____**Date:** ___/___/___

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Appointment Reminder Consent

Complete this form and sign below to give your permission for Lake Washington Physical Therapy to provide you with appointment notifications. **By default, our appointment reminder notifications are sent via text message.** If you would prefer a phone call or email reminder instead, please fill out the following information.

☐ **Email:** Lake Washington Physical Therapy may send email messages to confirm my upcoming appointment to _____ .

☐ **Phone:** I prefer to receive phone call reminders at this phone number_____.

***Our cancellation list notifications will also be sent via text, unless specified above.**

Patient / Guardian Signature: _____Date:_____