Wave Therapies

P.O. Box 3432 Redmond, WA 98073-3432 ~ Phone 206-782-5555 ~ Fax 425-868-9922 ~ E-Mail: jennifer@wavetherapies.com

Patient Information and Intake Form

Thank you for choosing Wave Therapies as part of your medical care team. It is our goal to provide you with outstanding, individualized physical therapy care, focused on your goals and outcome needs.

For your first visit please bring the following items: these completed forms, your prescription from your physician, and a copy of your insurance card. Please contact our office if you have any questions. Phone us at 206-782-5555 or by email at jennifer@wavetherapies.com. We look forward to working with you.

Patient Information

Patient Name _____

Date of Birth _____ **Age at first visit** _____

Billing Address _____

City _____ **State** _____ **Zip Code** _____

Phone number _____ **Work** _____ **Cell phone** _____

Referral Source _____

E-mail address _____

Billing information

Relationship: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insurance Company _____

Address _____

City _____ **State** _____ **Zip Code** _____

Subscriber Name _____ **Subscriber date of birth:** _____

Subscriber Group/Provider ID number _____

Co-Payment/visit _____ **Employer** _____

Secondary Insurance

Secondary Insurance Company _____

Secondary Subscriber Name _____

Subscriber ID number _____ **Date of Birth** _____

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Consent for Patient Care

Please read carefully. This document must be signed before treatment begins. A copy can be provided upon request.

As a courtesy to you, Wave Therapies Inc, LLC will bill your insurance company for you. You are responsible for the bill once services are rendered, however. You understand that you are responsible for all co-payments and other uncovered charges incurred during the course of treatment with Wave therapies Inc, LLC and agree to remit such charges to Wave Therapies Inc, LLC.

If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. If any payment is received from your insurance carrier beyond the balance due, you will be promptly refunded the credit. If any payment is remitted directly to you for services billed by Wave Therapies Inc, LLC you are responsible for remitting the same balance to Wave Therapies Inc, LLC.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I do hereby give consent for Wave Therapies Inc, LLC to treat me for the named condition(s) as outlined by my physician and deemed necessary by my therapist. Additionally, I agree to allow Wave Therapies to bill the above named insurance company/companies for these services on my behalf.

I also consent for Wave Therapies Inc, LLC to release all or part of my medical record to persons or corporations which are liable for all or any part of the charges for treatment. I assign my benefits under my medical insurance plan to Wave Therapies Inc, LLC.

I hereby give my permission for the staff of Wave Therapies Inc, LLC to take video/photos for the following reasons:

☐ My personal medical record reasons. These may be shared with your insurance company, physician, attorney or others directly involved in your care if requested.

☐ My photos/videos may be utilized for educational purposes.

☐ My photo/video may be utilized for publications, website or other print, digital or other media. Should my visual information be utilized in this manner I understand that my personal identifying information will not be utilized. I also understand that should information be utilized in this manner a $50 donation to the herafter named charity will be given by Wave Therapies. Charity (must be 503-C) name and contact:

☐ All of the above

☐ None of the above

I have received and read the HIPAA privacy practices established by Wave Therapies, LLC. I understand that should any changes be made to this policy I will receive a copy at my next scheduled session.

Signature _____ **Date:** _____

Parent/Guardian Signature: _____
(Required for patients under 18 years of age)

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Release of Information

I hereby give permission for the release of my health information to the following individuals or groups for the express purpose of enhancing my or my childs, treatment. I understand that only essential information will be communicated. Such information may or may not include chart notes, insurance information, or other documents relating to services obtained through Wave Therapies. I understand that I may amend this release at any time in writing which will take immediate effect, affecting all outgoing information from the time such a request is received.

Physicians: Please send ☐ reports ☐ other _____ to the following physicians:

1. Name _____

Address _____

City _____ State _____ Zip Code _____

2. Name _____

Address _____

City _____ State _____ Zip Code _____

School Services: Please send ☐ reports ☐ other _____ to the following school:

School _____ Attn _____

Address _____

City _____ State _____ Zip Code _____

Therapists: Please send ☐ reports ☐ other _____ to the following therapists:

1. Name _____

Address _____

City _____ State _____ Zip Code _____

2. Name _____

Address _____

City _____ State _____ Zip Code _____

Equipment: Please release information pertinent to obtaining required durable medical equipment to the following vendors/providers.

☐ Care Medical Equipment – Seattle, WA ☐ Cascade DAFO – Ferndale, WA

☐ Olympic Pharmacy – Gig Harbor, WA ☐ ATG Rehab – Lynnwood, WA

☐ Other _____

Signature _____ Date: _____

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Orthopedic Intake Form

Patient Name _____ **Date of injury/sympton onset** _____

Date of last prescription _____ **Referring Dr.** _____

Primary Diagnosis _____ **ICD9 code (if known)** _____

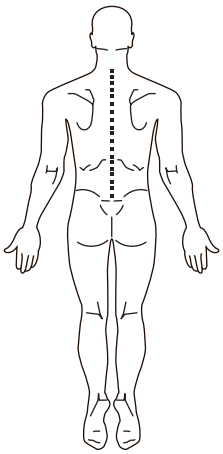
Secondary Diagnosis _____ **ICD9 code (if known)** _____

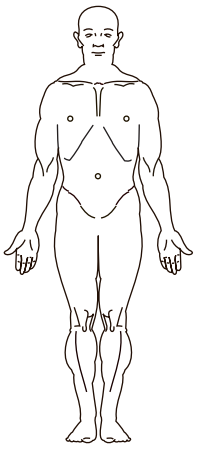
Surgical History:

Procedure _____ **Approximate date** _____

Medications:

Please indicate on the drawings where your pain is with arrows and indicate 1-10 what your pain is during your typical day(t). Please also note your pain (1-10) at its best (b) and at its worst (w). Feel free to make any other additional notes at the bottom of the page.





Please indicate with ///// areas of greatest weakness/sensory loss.

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Orthopedic Client Checklist

My symptoms are aggravated by *(check all applicable)*

☐ Standing ☐ Lying ☐ Walking
☐ Lifting ☐ Bending ☐ Twisting
☐ Other _____

My symptoms are relieved by *(check all applicable)*

☐ Standing ☐ Lying ☐ Walking
☐ Heat/cold ☐ Bending ☐ Medication
☐ Other _____

Prior to this event my level of function was

☐ Independent in all activities ☐ Independent with assistive devices ☐ Other _____

My prior medical history is significant for

☐ Orthopedic surgeries ☐ Cardiac concerns ☐ Blood Clots
☐ Diabetes ☐ Skin sores ☐ Pulmonary issues
☐ Bowel/Bladder issues ☐ Auto accident(s) ☐ Cancer

☐ Other, My medical history is also signicant for _____

_____

What are your goals in physical therapy? _____

_____

Since your event, have your symptoms improved, degraded or stayed the same? _____

Has your living situation or level of assistance changed as a result of your change in abilities? _____

Do you work? ◯ Yes ◯ No

Were you working prior to the onset of this issue? ◯ Yes ◯ No

If yes, please describe your jobs physical requirements. _____

What do you enjoy doing outside of your profession? _____

Are you still able to do that? _____

Do you wish to return to these activities? _____

Reset Print