



**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 ( ) \_\_\_\_\_

CLAIM # \_\_\_\_\_

*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.

→Reminder 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 FAWN COUSSENS, MSPT, LLC.
- I am financially responsible for any balance due.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# CONSENT FOR CARE AND FINANCIAL AGREEMENT

I (patient or legal guardian for patient who is minor) grant permission for Fawn Coussens, MSPT to perform such examinations and therapeutic procedures as may be professionally deemed necessary or advisable for appropriate evaluation and treatment of my condition.

As permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the release of any and all medical information to my physician(s) and other healthcare providers as may be necessary for communication regarding my care. Additional persons I would like my health information to be made accessible to are noted below.

As permitted by HIPAA, I authorize the release of any and all of my medical records to my insurance company at their request. Other release is subject to my written consent.

***I understand that all treatment fees are to be paid at the time of service unless other billing arrangements are made with Fawn Coussens, MSPT.*** Fawn Coussens, MSPT, LLC is a preferred provider with most major insurance companies. In cases where your insurance is not billed or Fawn Coussens, MSPT, LLC is not a preferred provider, Fawn Coussens will provide, on request, a superbill receipt that you may use to submit to your insurance carrier and/or keep for your personal records.

**If my insurance company (or other responsible party) rejects payment or shows that a portion is the responsibility of the patient, I agree to make full payment within 30 days of the first billing unless other arrangements are mutually agreed upon.** Exception will be made in cases where Fawn Coussens' contract with the insurer precludes this.

**If I "no-show" or cancel an appointment without providing 24 hours of notice (excluding weekends), I am responsible for paying the cancellation fee of \$65 before further treatment is provided.** These charges cannot be billed to insurance. Exceptions for emergent situations may be made. If I "no-show" two times, I understand that further appointments will be cancelled.

I request that all fees paid by my insurance company or other party be paid directly to Fawn Coussens, MSPT, LLC unless I have previously paid said fees directly to Fawn Coussens.

**Co-pays are due at the time of service.**

**I HAVE READ AND UNDERSTAND THE ABOVE POLICY.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

*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.*

I authorize the following persons to have access to my health information:

\_\_\_\_\_  
\_\_\_\_\_

**I HAVE RECEIVED, READ AND UNDERSTAND MY PRIVACY RIGHTS AND PRACTICES (HIPAA).**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## BILLING INFORMATION WORKSHEET

In order to fully understand physical therapy coverage under your insurance plan, we have developed this worksheet 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 ( ) \_\_\_\_\_
- 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 FAWN COUSSENS MSPT, LLC for payment of services? Yes/No
- Does this plan require a **prescription** from the **primary care physician** to FAWN COUSSENS MSPT, LLC for payment of services? 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 an in-network provider for the plan, what is the benefit coverage for FAWN COUSSENS, MSPT, LLC?  
(i.e., 60%, 80%, etc.). \_\_\_\_\_%

## Notice of Privacy Practices

### **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 a physical therapist reviews 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, emailing you or sending you a letter) to remind you about appointments or advise you about other services provided at Fawn Coussens, MSPT, LLC.

### **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.

### **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:  
4546 California Ave. SW Suite 202, Seattle WA 98116

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 Fawn Coussens, MSPT, LLC, Fawn Coussens, MSPT, LLC 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 Fawn Coussens, MSPT, LLC.

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 right 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.

# Subjective Intake Questionnaire

Today's date \_\_\_\_\_

Name: \_\_\_\_\_

Handedness

Right / Left

## Who referred you?

- Physician    Naturopath    ARNP    Chiropractor    Yoga / Pilates / Fitness instructor  
 Claims manager    Attorney    Other \_\_\_\_\_

## Chief Condition / Current Complaint

Please describe the problem(s) that bring(s) you to PT: \_\_\_\_\_

\_\_\_\_\_

## Describe your symptoms (please check and indicate body region or part and describe)

- Numbness \_\_\_\_\_    Tingling \_\_\_\_\_    Aching \_\_\_\_\_    Sharp pain \_\_\_\_\_  
 Dull pain \_\_\_\_\_    Burning \_\_\_\_\_    Dizziness/Lightheadedness  
 Loss of range of motion \_\_\_\_\_    Weakness \_\_\_\_\_    Functional changes (eg. difficulty with stairs) \_\_\_\_\_  
 Other \_\_\_\_\_

Are your symptoms related to an accident or specific injury? Y / N If yes, please describe

\_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Did your symptoms come on gradually? Y / N

Have you ever had this problem before? Y / N If yes, please describe

\_\_\_\_\_

Did they previously get better? Y / N How? Y / N \_\_\_\_\_

## What is the frequency of your symptoms?

- Constant    Daily \_\_\_\_\_x/Day    Weekly \_\_\_\_\_x/week

How are your symptoms progressing?  Improving    Worsening    Staying the same

What makes your symptoms better?  Heat    Ice    Exercise    Rest    Medication

Change position    Walking    Other \_\_\_\_\_

What makes your symptoms worse?  Sitting    Rising from sit to stand    Standing

Walking    Bending    Squatting    Stairs    Kneeling    Computer    Lifting    Other

\_\_\_\_\_

Are you able to continue working?  Yes, full duty    Yes, Light duty    No, as of \_\_\_\_\_

Are you able to continue your usual recreation?  Yes    Limited \_\_\_\_\_

Do you have periods of time when you are completely symptom free? Y / N

Do your symptoms awaken you at night? Y / N

If yes, how many times? \_\_\_\_\_/night   What time? \_\_\_\_\_am/pm

**Have you experienced any of the following with your current problem?**

- Buckling
- Loss of balance
- Pain with cough/sneezing
- Lip numbness
- Locking
- Dislocating
- Bowel/bladder changes
- Unconsciousness
- Giving way
- Dizziness/blurred vision
- Numbness around groin

**What treatment have you had for this complaint? (check all that apply)**

- None
- Acupuncture
- Massage therapist
- Osteopath
- Rheumatologist
- Physical Therapy when \_\_\_\_\_ #visits \_\_\_\_\_
- Chiropractor
- OB/Gynecologist
- Pediatrician
- Psychiatrist
- Dentist
- Orthopedist
- Podiatrist
- Psychologist
- Physician
- Occupational therapist
- Neurologist/Neurosurgeon

**Social/Health Information**

Do you currently smoke? Y / N Amount \_\_\_\_\_

Did you smoke in the past? Y / N When quit? \_\_\_\_\_

Do you exercise regularly? Y / N

How many times per week? \_\_\_\_\_ How long per bout? \_\_\_\_\_

Please describe your exercise \_\_\_\_\_

**Living Information**

Does your home have:  stairs  railing  uneven terrain  other concerning obstacles \_\_\_\_\_

Do you use:  cane  walker  wheelchair  crutches  other assistive devices \_\_\_\_\_

**General Health Status**

Please rate your average health:  excellent  good  fair  poor

Have you had any major changes in the recent year (i.e. new baby, death in family, job change, etc?)

Y / N please describe \_\_\_\_\_

**Medical/Surgical History**

- Arthritis
- Blood disorder
- High blood pressure
- Diabetes/High blood sugar
- Head injury
- Muscular dystrophy
- Allergies
- Cancer
- Repeated infections
- Other \_\_\_\_\_
- Broken bones/fractures
- Circulation/vascular disorder
- Lung problems
- Depression
- Parkinson's disease
- Thyroid conditions
- Kidney Problems
- Ulcer/stomach problems
- Osteopenia/Osteoporosis
- Heart problems
- Stroke
- Low blood sugar/hypoglycemia
- Multiple sclerosis
- Seizures/Epilepsy
- Developmental/growth problems
- Infectious disease(HIV, TB, HepC)
- Skin disorders

**Within the past year, have you experienced any of the following symptoms?**

- Chest pain
- Shortness of breath
- Loss of balance
- Joint pain/swelling
- Loss of appetite
- Weight loss/gain
- Hearing changes
- Other \_\_\_\_\_
- Heart palpitations
- Dizziness or blackouts
- Difficulty walking
- Pain at night
- Nausea/vomiting
- Urinary problems
- Vision changes
- unexplained cough
- Coordination problems
- Weakness in arms or legs
- Difficulty sleeping
- Bowel problems
- Headaches
- Numbness/tingling \_\_\_\_\_

**Medications- check ALL Physician prescribed medications currently taking:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aspirin         | <input type="checkbox"/> Tylenol/acetaminophen      | <input type="checkbox"/> Anti-inflammatories         |
| <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Birth control pills        | <input type="checkbox"/> Prescription pain relievers |
| <input type="checkbox"/> Antibiotics     | <input type="checkbox"/> Stomach ulcer medication   | <input type="checkbox"/> Hormone replacement therapy |
| <input type="checkbox"/> Diuretics       | <input type="checkbox"/> Thyroid medications        | <input type="checkbox"/> Heart medications _____     |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Seizure medications        | <input type="checkbox"/> Asthma medications          |
| <input type="checkbox"/> Insulin         | <input type="checkbox"/> Decongestant/antihistamine | <input type="checkbox"/> Steroids                    |
| <input type="checkbox"/> Other _____     |   |  |

**Medications- check ALL non-prescription medications currently taking:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Aspirin                  | <input type="checkbox"/> Antacids (Tums, etc) | <input type="checkbox"/> Advil/Aleve/Motrin/Ibuprofen |
| <input type="checkbox"/> Decongestants            | <input type="checkbox"/> Laxatives            | <input type="checkbox"/> Tylenol/acetaminophen        |
| <input type="checkbox"/> Herbal supplements _____ |   |   |
| <input type="checkbox"/> Other _____              |   |   |

**Other Clinical Tests and Radiology**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Angiogram                | <input type="checkbox"/> Echocardiogram (EKG)         | <input type="checkbox"/> Electroencephalogram (EEG)           |
| <input type="checkbox"/> MRI _____                | <input type="checkbox"/> CT scan _____                | <input type="checkbox"/> Electromyogram (EMG)                 |
| <input type="checkbox"/> X-Ray _____              | <input type="checkbox"/> Myelogram                    | <input type="checkbox"/> Bone Scan                            |
| <input type="checkbox"/> Blood tests              | <input type="checkbox"/> Spinal tap                   | <input type="checkbox"/> Stress tests (eg. Bike or treadmill) |
| <input type="checkbox"/> Pulmonary function tests | <input type="checkbox"/> Nerve conduction tests (NCV) |   |
| <input type="checkbox"/> Other _____              |   |   |

**Have you ever had surgery? Y / N** If yes, please describe area and date:

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**Thank you!!**