BELLEVUE BOWEN & OCCUPATIONAL THERAPY SERVICES, LLC

Tel: (425)818-5007 Fax: (206)774-7903 bellevuebowen@gmail.com

PATIENT & INSURANCE INFORMATION

Patient Information:

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
SS #: _____ Birthdate: _____ Sex: □F □M
Home Phone #: _____ Work Phone #: _____
Cell Phone: _____ E-mail:_____

Doctor: _____ Dr. Phone/Fax: _____
In case of emergency, please contact: _____
Relationship to patient: _____ Phone #_____

Responsible party information, if different from patient:
(This office offers the courtesy of Insurance Billing, however, we do not have a contract with all companies.)

Last Name: _____ First Name: _____ MI: _____
Address:_____
City:_____ State:_____ Zip:_____
Employer/School Name: _____ Employer/School Address: _____
_____

Insurance Information:

Primary Insurance:

Insured's Last Name: _____ First Name: _____ MI:_____
Insured's Birthdate: _____ Sex: □F □M Insured's SS#: _____ Rel. to pt.:_____
Insurance Co.: _____ Cust. Service Phone#: _____
Insurance Co. Address: _____
Member ID: _____ Group #: _____ Plan #: _____

If L&I: Claim # _____ Date of Injury: _____
Claims Manager: _____ Claims Mgr. Phone#: _____

If Motor Vehicle Accident: Claim#_____ Date of Accident: _____
Claims Manager: _____ Phone #: _____

I understand, as the patient and/or above mentioned responsible party, that I am fully responsible for payment of all charges incurred. I understand that, where appropriate, credit bureau reports may be obtained.
I also understand that if I no-show or late cancel with less than 24 hours notice I will accrue a $50 fee for an hour appointment and a $75 fee for an hour and a half or longer appointment.

I authorize my insurance benefits to be paid directly to Bellevue Bowen & Occupational Therapy Services, LLC for services rendered. I understand I am financially responsible for any deductibles, non-covered services, or non-authorized services. I authorize Bellevue Bowen & Occupational Therapy Services, LLC to release any information requested by the insurance company with regards to payment of benefits. (print to sign)

Signature _____ Date _____

BELLEVUE BOWEN & OCCUPATIONAL THERAPY SERVICES, LLC

Tel: (425)818-5007 Fax: (206)774-7903 bellevuebowen@gmail.com

MEDICAL HISTORY

1. Please list your current health concerns in order from most bothersome to least bothersome. Please include mental, emotional and physical concerns.

a. _____ c. _____
b. _____ d. _____

2. Have you had any tests for your current symptoms? □Yes □ No

If yes, check: □ X-ray □ Bone Scan □ CAT Scan □ MRI □ Nerve Conduction Test
□ Other: _____
Results:_____

3. Do you currently have or have you had a history of the following:

□ AIDS
□ Artificial Joints
□ Heart Murmur
□ Arthritis
□ Artificial Heart Valves
□ Allergies
□ Asthma
□ Heart Trouble
□ Cardiac Pacemaker
□ Diabetes
□ Anemia
□ Cancer Treatment
□ High Blood Pressure
□ Psychiatric Treatment
□ Stroke

4. Are you currently taking medication for this or any other medical problem? □ Yes □ No
If yes, please list: _____

5. Please list all previous surgeries/ procedures and dates:

a. _____ c. _____
b. _____ d. _____

SUBJECTIVE EVALUATION

1. What is your primary complaint? _____

2. Describe how and when your symptoms began: _____
_____

3.Mark on the scale your current level of discomfort: □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
0 = No pain at all *10= Worst pain imaginable*

4. What aggravates your symptoms? _____

5. What eases your symptoms? _____

6. If appropriate, comment on the following: How do symptoms change in the morning? _____

Throughout the day? _____ In the evening? _____

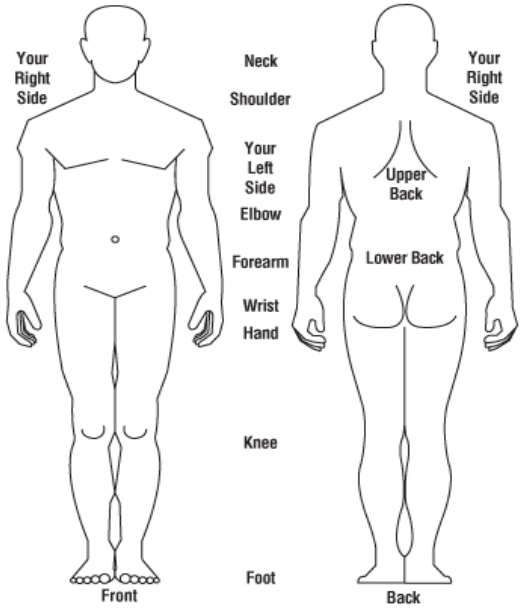
7. Overall how have your symptoms progressed? □Getting better □Unchanged □Getting worse
Explain how:_____

8. Have you had treatment for your current symptoms? □ Y □ N If yes, describe treatment and results:
_____

BELLEVUE BOWEN & OCCUPATIONAL THERAPY SERVICES, LLC

Tel: (425)818-5007 Fax: (206)774-7903 bellevuebowen@gmail.com

9. On the body chart below, please mark your symptom areas:



10. What is your work/hobby? Work: _____ Hobby: _____

11. Are you currently working? □ Yes □ No If no, is it because of your symptoms? □ Yes □ No

12. Describe the physical demands of your work: □ Heavy □ Moderate □ Light □ Sedentary
Specifics: _____

13. Describe the physical demands of your recreational activities or hobbies: _____
_____

14. Are you able to participate in your recreational activities or hobbies: □ Yes □ No
If no, explain: _____ _____

15. Are you having difficulty performing your daily activities? □ Yes □ No
If yes, explain: _____

16. What do you think is the cause of your symptoms? _____
_____

17. What are your goals for Therapy? _____
_____

The above information is true and complete, to the best of my knowledge. (print to sign)

Signature of Patient / Guardian: _____ Date: _____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date: _____

BELLEVUE BOWEN & OCCUPATIONAL THERAPY SERVICES, LLC

Tel: (425)818-5007 Fax: (206)774-7903 bellevuebowen@gmail.com

NOTICE OF PRIVACY PRACTICES

(Required by law)

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us be kept properly confidential. As required by "HIPAA", following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

• **Treatment** – providing, coordinating, or managing health care and related services by one or more health care providers.
• **Payment** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
• **Health care operations** – include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a staff member of Bellevue Bowen & Occupational Therapy Services, LLC.

• The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to request a copy of our current *Notice of Privacy Practices* at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above. (print to sign)

Signature of Patient / Guardian: _____ Date:_____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date:_____

Signature: _____ Date: _____