Dear New Patient,

We look forward to meeting you! Feel free to browse our website to get to know our staff and clinic.

This packet contains:
- Patient Registration
- Patient History
- Financial Policy
- Notice of Privacy Practices

Please bring to your appointment:
- Signed and completed forms listed above
- Doctor's written prescription or referral
- Insurance card so that we may photocopy the necessary information
- Drivers License so that we may scan into your electronic record

Orthotic Evaluations
- Please bring a selection of shoes that you wear daily and/or active in (sports shoes, work shoes, etc)
- A pair of shorts or pants which can be rolled above the knee

Please plan for a 45 minute appointment. Should you have any questions regarding your appointment, please feel free to call our office at (206) 518-9405.

A map to our office can be found on our website at **g4athlete.com/contact**

G4athlete
LIGHT YEARS

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	___ MALE ___ FEMALE

BILLING ADDRESS	CITY	STATE	ZIP	HOME PHONE

EMPLOYER NAME/SCHOOL NAME	CELL PHONE

EMAIL ADDRESS	WORK PHONE

HOW DID YOU HEAR ABOUT US?

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE

Date you were last seen by your referring physician: _____

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST	MI

PRIMARY PHONE	SECONDARY PHONE

RELATIONSHIP: SPOUSE PARENT ___ GUARDIAN	PARENT OR GUARDIAN EMAIL ADDRESS

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY

RESPONSIBLE PARTY SIGNATURE X	DATE

CONSENT TO TREAT

I DO HEREBY CONSENT TO TREATMENT BY THE AUTHORIZED PERSONNEL OF G4 ATHLETE. THIS TREATMENT WILL BE DICTATED BY PRUDENT MEDICAL PRACTICE BASED ON MY INJURY OR CONDITION.
FOR TREATMENT OF MINORS: THE BELOW RESPONSIBLE PARTY REPRESENTS THAT THEY ARE LEGALLY AUTHORIZED TO OBTAIN MEDICAL SERVICES FOR THE PATIENT.

_____ _____ _____
Patient Printed Name Patient Signature Date

PATIENT HISTORY

Name: _____ Male: ____ Female: ____ Date: _____

Age: ____ Height: _____ Weight: _____ Occupation: _____

CHIEF COMPLAINT AND PRESENT ILLNESS:

Area of injury/symptoms _____ Date your symptoms/injury started _____

How did your symptoms start? _____

Diagnosis from your doctor _____ Date of your next doctor recheck _____

Primary reason for attending therapy?

__ pain
__ limited motion
__ weakness
__ activity reduction
__ loss of independence
__ unable to work
__ unable to do household tasks
__ unable to play sports or do recreation

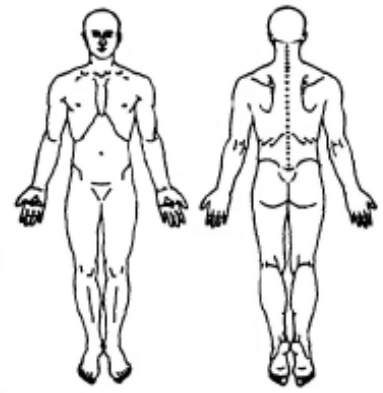
Are you currently off work because of this problem _____ no _____ yes; if yes, last day worked: _____

Using the diagram, circle the specific area of pain. If pain travels, draw arrows.

Please RATE your pain level. No pain __1 __2 __3 __4 __5 __6 __7 __8 __9 __10 Worst pain

How would you DESCRIBE your pain?

__ dull ache __ burning __ heavy __ sore
__ deep ache __ throbbing __ twinge __ other
__ stabbing __ squeezing __ cramp
__ nagging __ drawing __ sharp



Do you have any numbness/tingling? _____Where? _____

Prior to this onset, were you free of these symptoms? Yes _____ No _____ Explain

_____

What eases the pain? _____

_____

What aggravates the pain? _____

Have you had any other treatment for this problem? ___What? Chiropractic _____Physical Therapy _____Other _____

Did it help? _____

Do you feel you are __ **getting better**, __ **getting worse** or __ **staying the same** ? (check one)

Are you pregnant? Yes _____ No _____ Which trimester? 1 _____ 2 _____ 3 _____

Have you had x-rays? Yes _____ No _____ Findings? _____

Have you had an MRI? Yes _____ No _____ Findings? _____

Please list any other tests you have recieved: _____

_____

Any other concerns or health changes since the start of this injury/illness? _____

_____ _____

Patient (parent or guardian, if minor) Date

ACTIVITIES OF DAILY LIVING:

Circle activities that are difficult for you and then check the appropriate box

	WITH DIFFICULTY/PAIN	CANNOT PERFORM
PERSONAL HYGIENE: __ hair __ bathing __ toilet	☐	☐
DRESSING: __ zippers/buttons __upper body __ lower body __ shoes	☐	☐
HOUSEHOLD CHORES: __ reach overhead __ lifting/carrying __dust __ vacuuming __ mopping MEAL PREPARATION: __ use of stove __ dishes	☐	☐
YARD/GARDEN: __ mowing __ tilling __weeding __ raking __ watering	☐	☐
WALKING: __ stairs __ curbs __ incline__decline __uneven ground __ distances TRANSPORTATION: __ Drive self __ ride with others __ bus __ taxi __ shopping	☐	☐

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem):

GENERAL MEDICAL

Have you EVER been diagnosed as having any of the following conditions?

A. Cancer	__ YES	If yes, describe what kind: _____
B. Heart Problems	__ YES	
C. High Blood Pressure	__ YES	
D. Asthma	__ YES	
E. Emphysema	__ YES	
F. Chemical dependency (e.g. alcoholism)	__ YES	
G. Thyroid Problems	__ YES	
H. Diabetes	__ YES	
I. Multiple Sclerosis	__ YES	
J. Rheumatoid Arthritis	__ YES	
K. Other arthritic problems	__ YES	
L. Depression	__ YES	
M. Hepatitis	__ YES	
N. Tuberculosis	__ YES	
O. Stroke	__ YES	
P. Kidney disease	__ YES	
Q. Anemia	__ YES	
R. Epilepsy	__ YES	
S. Insomnia	__ YES	
T. Constipation/Diarrhea	__ YES	
U. Other	__ YES	

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you here, please describe for what reason: _____

_____

Please list any SURGERIES or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization: _____

_____

Please describe any INJURIES for which you have been treated (including fractures, dislocations, sprains) and the approxmate date of injury.

Date: _____ Injury: _____

MEDICATIONS

Please list ALL PRESCRIPTION medications you are currently taking for this and any other condition (including pills, injections, and/or skin patches): _____

Check any of the following OVER-THE-COUNTER medication you have taken in the last week or that you take regularly:

A. Aspirin	__ YES
B. Tylenol	__ YES
C. Advil / Motrin / Ibuprofen	__ YES
D. Laxatives	__ YES
E. Decongestants	__ YES
F. Antihistamines	__ YES
G. Antacids	__ YES
H. Vitamins / mineral supplements	__ YES
I. Herbs	__ YES
J: Other	__ YES

GOALS:

Your personal goals for therapy. Please choose 3 -4 that are most important to you.

_____ Relieve/reduce pain
_____ Learn self-care techniques and prevention's
_____ Resume/Improve self-care activities, i.e. dressing, fixing hair, etc.
_____ Resume/Improve household chores, i.e. vacuuming, cleaning, etc.
_____ Resume/Improve yard work, gardening, etc.
_____ Return to work activities; specify:
_____ Return to sports/recreation/hobbies; specify:
_____ Regain mobility/increase flexibility
_____ Regain strength/increase strength
_____ Increase sitting tolerance
_____ Increase standing tolerance
_____ Increase walking distance and speed
_____ Improve posture
_____ Improve sleep
_____ Learn proper body mechanics - how to do what you do correctly

The above information is true and complete, to the best of my knowledge.

Signature of Patient / Guardian: _____ Date:_____

G4 Athlete Financial Policy Statement

It is important that you have a clear understanding of your financial commitment for services provided by G4 Athlete. We are happy to discuss fees prior to treatment so that you may fully understand the financial responsibilities.

Insurance plans are not designed to pay for everything. It is very important that you read your policy and understand the benefits within your plan. As a courtesy we verify your physical therapy benefits prior to treatment but this is NOT a guarantee of insurance payment.

Our services include filing **insurance claims** on your behalf. Once your claims are processed, you will receive a statement of patient responsibility which will include deductibles and co-insurance. Your insurance may also deny payment for other reasons. All charges are your responsibility from the date services are rendered.

Copays are due at the time of service. We accept VISA, MasterCard, American Express, HSA cards, checks and cash payments. We prefer to keep a credit card on file for all copays.

Our **cancellation policy** requires 24 hour notice. We make every attempt to confirm appointments by email or phone. We reserve the right to apply a missed appointment charge of $100 for late notification or failure to show.

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I have read and understand the Financial Policy terms above. I accept financial responsibility for services at G4 Athlete and as the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

_____

Responsible Party Signature Date

ASSIGNMENT OF INSURANCE BENEFITS

I authorize G4 Athlete to receive assignment of insurance payments in the event that they file insurance on my behalf. I hereby authorize G4 Athlete to release all information necessary to secure payment of said benefits from insurance company.

_____

Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES

(Required by law)

Effective 9/1/02

The Health Insurance Portability and Accountability Act (HIPPA) 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 member of the G4 Athlete staff.

- 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 alsounderstand my rights as outlined above.

Patient (parent or guardian, if minor) _____ Date _____