BALANCE PHYSICAL THERAPY INC.
730 NW Gilman Blvd
Suite C-108
Issaquah, WA 98027
Ph: (425) 391-6794
Fx: (425) 391-1525
www.balancept.org

MOTOR VEHICLE ACCIDENTS

PATIENT INFORMATION (Please Print)

Patient's Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like to receive email reminders? ☐ Yes ☐No Email Address: _____

Gender: _____ Date of Birth: _____

Employer Name:_____ Job Title/ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Auto Claim Information

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other Insurance Company Name _____

Ins Co. Address_____ City _____ State_____ Zip_____

Adjuster's Name _____Adjuster's Phone Extension (_____)_____

Policy Holder's Last Name_____ First Name_____ Middle _____

Policy Holder's Address_____ City _____ State _____ Zip _____

Policy Holder's Date of Birth _____/_____/_____ Policy Holder's Employer _____

Claim Number _____ Accident Date _____/_____/_____

Attorney Name _____ Phone _____

Personal Injury Protection (PIP) Information

Do you know the amount of Personal Injury Protection (PIP) of your motor vehicle insurance policy? $_____

Do you know the current amount available? $_____

Have you previously or are currently receiving any other treatment on a regular basis under this claim? ☐ Yes ☐ No

Are you aware of any large expenses that will apply towards your PIP such as MRI or surgery? ☐ Yes ☐ No

If yes, please explain: _____

Primary Medical Insurance

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other Insurance Company Name _____

Subscriber's Last Name_____ First Name_____ Middle _____

Subscriber's Address (if different) _____Apt_____

City _____State_____Zip_____

Policy ID number _____ Group Number _____

Subscriber's Date of Birth _____/_____/_____ Subscriber's Employer _____

Secondary Medical Insurance

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other Insurance Company Name _____

Subscriber's Last Name _____ First Name _____ Middle _____

Policy ID number_____ Group Number_____

Subscriber's Date of Birth_____/_____/_____ Subscriber's Employer_____

CONSENT FOR CARE:

Please read carefully and sign prior to treatment. If a copy of this release is desired, one will be provided for you.

Though it is our policy to bill the insurance carrier directly as a courtesy to our patients, please note that the patient is responsible for the entire bill when services are rendered. If, for any reason, your insurance carrier does not remit payment within 90 days of billing, the patient is responsible for the balance in full. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to BALANCE PHYSICAL THERAPY INC., PS (BALANCE PT). Once you have received a statement from BALANCE PT, all past due patient balances over 30 days will be subject to a $25.00 per month administrative late statement fee and interest charges of 12% per annum (1% per month).

If you motor vehicle insurance does not pay for any portion of your claims, in some circumstances we can bill your private insurance. Beginning 1/1/2025 we require that patients with an unmet deductible make an estimated payment due at time of service. Your estimated amount is based on your specific insurance plan and coverage. Please see your "Deductible, Copay, and Co-Insurance Form" specific to your plan for estimated amounts. This estimated payment per visit will be collected until your unmet deductible is satisfied. Once your deductible is satisfied, any estimated co-insurance and/or co-pay responsibility will be collected at time of service. All estimated payments and co-pays made in the office will not be reflected on your insurance carrier's EOB, however, monies collected at time of service will be reflected on your patient statement. If at any time it is determined that BALANCE PT has collected more than you owe, a prompt refund will be made. If amounts collected are insufficient to meet your patient responsibility, BALANCE PT will provide you a statement.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by BALANCE PT, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I hereby consent to and authorize all physical therapy treatments and procedures which may be considered advisable or necessary in the judgment of the patient's licensed physical therapist. BALANCE PT may disclose portions of the patient's records to any person, insurance company or corporation which is or may be liable for all or any portion of the charges for treatment. I assign my benefits under my medical insurance plan BALANCE PT. A copy, facsimile, or scan of this signed document is considered as valid as, and has the same force as, the original document.

Should any provision or portion of this Agreement be held unlawful or unenforceable, the balance of this Agreement shall be nonetheless in all respects remain binding and effective and shall be construed to be in full force and effect to the extent lawfully permissible.

Patient, Parent, or Guardian Signature _____ Date _____

Printed Name: _____

Relationship to patient _____ Witness _____

UPDATED CANCELLATION POLICY FOR 2025

In order to best serve our patients, it is necessary that you give us at least a 24-hour notice of cancellation for any scheduled physical therapy appointments with BALANCE PT. Fees for **excessive** late arrivals, late cancels, and no shows will be your responsibility as follows:

- **$15 nonrefundable charge** for a 15-minute late arrival (5-20 minutes = $15 fee)
- **$30 nonrefundable charge** for a half-hour late arrival (20-35 minutes = $30 fee)
- **$30 nonrefundable charge** for a no show or late canceled half-hour appointment
- **$60 nonrefundable charge** for a no show or late canceled one-hour appointment

These **nonrefundable charges** will be billed to **you** for any appointments that are missed and not cancelled at least 24 hours prior to the appointment. These charges will **NOT** be billed to your insurance company and are your responsibility, due at your next scheduled appointment. When you have two or more no shows or late cancels you may be moved to same day scheduling. We understand that emergencies and illness do occur that are out of your control, and BALANCE PT reserves the right to waive late arrival and cancellation charges.

I agree to the above cancellation policy:_____ Date:_____

Privacy Practices - HIPAA

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described above, talk to us. Tell us what you want us to do, and we will follow your instructions.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information
- We will let you now promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Please let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the terms of this notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website – www.balancept.org.

Effective 01/01/2025 - This Notice of Privacy Practices applies to the following organizations:

Balance Physical Therapy Inc., P.S. – a Washington State Corporation

Records Agent – Kira Leek, PT, CEO 425-391-6794 phone, kira@balancept.org

I Acknowledge receipt of Balance Physical Therapy's Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

Additional Requests: _____