Welcome to Lone Lake Physical Therapy!

What you should know before your first session:

Lone Lake Physical Therapy provides high quality individualized care. By choosing our facility, you will be working with one of our highly skilled practitioners. Each practitioner has their own specialty. Whether it is movement education, fascial tension normalization, balance, neurological rehabilitation or soft tissue work; your therapist will individually work with you to create a personalized treatment plan. We will help to alleviate the pain and limitation from your condition, and help you to be as active as possible.

What you should wear for physical therapy:

Please wear comfortable, loose, non-restrictive clothing or bring something to change into. Most treatments are provided through the clothing (with a few exceptions where skin contact is a necessity). Some clothing can make treatment more difficult or more uncomfortable for you. Female clients should avoid wearing underwire bras (if possible) as these often get in the way and can be uncomfortable during several of the techniques. Treatments can require movements that may seem immodest without proper clothing, please do not wear skirts or dresses. Please avoid wearing jeans, belts, or heavy shirts.

What to do after your first session:

Please allow yourself 2-3 days to assess the impact of your treatment (this means to avoid strenuous exercise – stressing healing tissues too quickly will encourage them to revert to their former pain producing patterns). Rest and hydration are the best things you can do. A 15 min walk after treatment is often helpful.

PLEASE NOTE: Our main goal is to help you meet your goals. Sometimes you may benefit from working with more than one specialist, or a different therapist than the one you start with. Your therapist will complete regular evaluations of your progress and will discuss with you if the opportunity to work with another practitioner would help you maximize your physical potential.

At LLPT we consider ourselves partners on your path to improved wellbeing. Other health care pracitioners may be important for your optimal health and we respect and encourage you to have a whole team behind you. However, the most important person on this team is you.

Lone Lake Physical Therapy, LLC

360-321-4434
PO BOX 260,
Langley, WA 98260

Patient Responsibility:

As you commit yourself to better health , you have some responsibilities we would like you to keep in mind. Please initial below, to let us know that you have read these guidelines and agree to make them a priority.

1. **Regular movement.** Your therapist will give you exercises, postural cues, and ways to avoid reproducing your pain or strengthen your body to help prevent injury. These exercises need to be done every day in order to maximize your recovery. In addition, we want you to just move- walk, bike, swim, dance – whatever you enjoy, at least 30 min every day in addition to your normal daily activities. _____

2. **Stress control.** Sometimes we cannot control the stressors in our lives, but many times we can. What increases your stress level? This is a hindrance to your wellbeing. If you cannot change your stressors, what can you do to help minimize the stress level within your body? We are here to help if you need ideas or support. _____

3. **Diet.** What is happening in your digestive system is being shown more and more to affect your physical health and emotional wellbeing. Creating a healthy internal environment starts with what you chose to eat. If you want to prevent exacerbation of your condition and maximize your ability to heal, a healthy diet is the best place to start.
We can help with guidance to point you to specialists if you need that as a part of your team. _____

4. **Rest.** Both your sleep at night, and having some rest time during the day is critical for healing and preventing disease, learning and improving mood. Make a commitment to yourself to set up routines to sleep well and take a little time for yourself each day. _____

5. **No scents**. Please respect the needs of those around you, specifically refrain from using any scented products the day of, or smoking within an hour of coming into the building. _____

I promise to participate fully as a member of my health care team. I agree to participate in the self-care program we select. I promise to inform my therapist any time I feel uncomfortable or that a treatment is not working towards my well-being.

CLIENT SIGNATURE: _____ DATE: _____

Lone Lake Physical Therapy, LLC
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PO BOX 260,
Langley, WA 98260

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY:_____
STATE: _____ ZIP:_____
PHONE: _____ MOBILE: _____WORK:_____
EMAIL ADDRESS: _____

May we use this address for contacting you regarding:

□ your care at LLPT (appointment reminders, etc) □ LLPT information and events

**please note that we do use not encrypted emails at LLPT, although our email service is HIPPA compliant*

EMPLOYER: _____ POSITION: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

SEX: female male
(Please make sure the sex you provide here is the same as your health record/insurance provider has on file.)

WHICH PRONOUNS DO YOU PREFER? she/her/hers he/him/his they/them/theirs

How did you hear about Lone Lake Physical Therapy? _____

NOTICE OF PRIVACY POLICY:

I have reviewed the Privacy Policy Notice of Lone Lake Physical Therapy, LLC

Please note, because of HIPAA if you are a patient in this clinic, and we do not know you through other means in the community, we will respect your privacy and will not acknowledge you in the community. You may initiate interactions at your discretion. Similarly, will not initiate discussion of the condition bringing you in for therapy.

CLIENT SIGNATURE: _____ DATE: _____

CANCELLATION/NO SHOW/LATE ARRIVAL POLICY:

Two business days' notice is required to cancel an appointment. If you cancel with less than two business days' notice or do not show up for your appointment, you will be charged a **$50.00 late cancellation/no show fee**. Late arrivals may incur a **$25 fee**. Insurance companies will not pay these fees.

I agree to the stated cancellation/no show/late arrival policy.

CLIENT SIGNATURE: _____ DATE: _____

Lone Lake Physical Therapy, LLC
360-321-4434
PO BOX 260,
Langley, WA 98260

CONSENT FOR TREATMENT:

I authorize and consent to physical therapy/massage services from Lone Lake Physical Therapy, LLC. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health or concerns regarding care in this facility.

CLIENT PRINTED NAME: _____

CLIENT SIGNATURE: _____ DATE: _____

CONSENT TO DISCUSS MEDICAL CARE:

I authorize Lone Lake Physical Therapy, LLC to discuss my medical information with the individuals I have listed below, in addition to my referring provider and insurance company.

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

This authorization shall remain effective unless revoked by me in writing.

CLIENT SIGNATURE: _____ DATE: _____

CONSENT FOR MEDICAL PHOTOGRAPHY:

I authorize the staff at Lone Lake PT to take photographs of me solely for use in my medical records, to assist with posture awareness and tracking my progress.

CLIENT SIGNATURE: _____ DATE: _____

CONSENT FOR TREATMENT OF A MINOR:

I, _____, the parent or legal guardian of my child, _____ authorize and consent to physical therapy services from Lone Lake Physical Therapy, LLC for my child. This authorization shall remain effective unless revoked by me in writing.

PARENT/GUARDIAN OF

CLIENT SIGNATURE: _____ DATE: _____

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SELF-PAY:

LLPT will accept self-pay for its services if you either do not have insurance, we are not a preferred provider with your insurance, or for a service your insurance company does not cover (like wellness care). Payment must be paid the day of service; we are unable to bill for self-pay treatments.

Physical Therapy:

1 hour initial evaluation with a PT: $150.00
1 hour subsequent appointment with a PT: $125.00
1 hour subsequent appointment with a PTA: $105.00

Massage Therapy:

30 minute massage: $50.00
60 minute massage: $90.00
90 minute massage: $130.00

FINANCIAL AGREEMENT FOR SELF-PAY:

I am financially responsible for the payment of balance due for services received from Lone Lake Physical Therapy, LLC **at the time of service**.

CLIENT SIGNATURE: _____ DATE: _____

INSURANCE BILLING:

LLPT is a preferred provider for **Physical Therapy** with Regence, Uniform Medical, Premera, LifeWise, Kaiser, L&I, and Medicare. ***Please note we cannot bill Medicare plans that are managed by an insurance company we are not contracted with! * Massage** is covered by Department L&I and motor vehicle claims.

FINANCIAL AGREEMENT FOR BILLING INSURANCE:

The information I have provided is correct to the best of my knowledge. I understand that Lone Lake Physical Therapy, LLC may bill my insurance company for the services provided**. I am financially responsible for deductibles, coinsurance, co-pays and services not covered by my insurance provider.** I authorize LLPT to furnish the responsible insurance company and other authorized parties with necessary information to process physical therapy/massage claims on my behalf. I authorize the payment of medical benefits to Lone Lake Physical Therapy. I am financially responsible for the payment of balance due, including all fees denied for services based on inaccurate information provided on this form. The below Physical Therapy/Massage benefits are accurate to the best of my knowledge.

CLIENT SIGNATURE: _____ DATE: _____

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****PLEASE ATTACH A COPY OF YOUR INSURANCE CARD****

ARE YOU ENROLLED IN MEDICARE PART B? YES NO

PRIMARY INSURANCE:

PRIMARY INSURANCE: _____ POLICY ID #_____

POLICY GROUP #_____ CLAIM #_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S DATE OF BIRTH:_____

SUBSCRIBER RELATION TO PATIENT: ϒ SELF ϒ SPOUSE ϒ PARENT ϒ OTHER

DEDUCTIBLE: $ _____ (Your deductible is the amount you need to pay for covered health care services before your health insurance or plan begins to pay. This means that **you will be responsible to pay 100%** of the physical therapy charges you accrue until you have met this amount total for all your medical services for the year, in addition to what is listed as your co-pay or co-insurance.)

CO-PAY: $_____ (This fee is paid at the time of service for each session.)

CO-INSURANCE: _____% (This is a % of the physical therapy charges that you will be responsible for after your insurance has paid the remaining %.)

ALLOWED NUMBER OF PT VISITS: _____ ALLOWED NUMBER OF MASSAGE VISITS:_____

Please verify if PT and massage are combined benefits on your plan: Yes No

SECONDARY INSURANCE:

SECONDARY INSURANCE: _____ POLICY ID #_____

POLICY GROUP #_____ CLAIM #_____

SUBSCRIBER'S NAME:_____ SUBSCRIBER'S DATE OF BIRTH:_____

SUBSCRIBER RELATION TO PATIENT: ϒ SELF ϒ SPOUSE ϒ PARENT ϒ OTHER

Lone Lake Physical Therapy, LLC

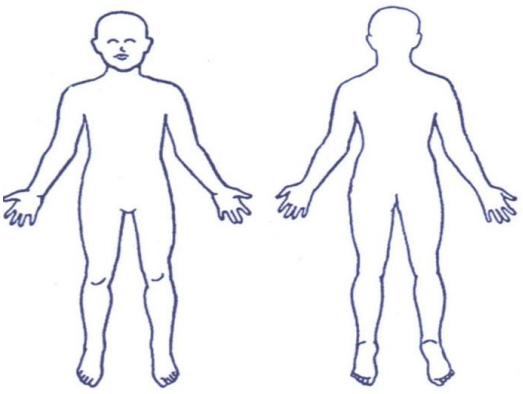
NAME_____

Condition bringing you to physical therapy/massage:

_____

_____

When did this start? _____



Right Left Left Right

Please mark the areas affected by your current condition on the pictures to the right:

Overall my condition is (circle one):

getting better getting worse staying the same

Previous treatment for this condition:

_____

_____

Current exercise habits:

_____

_____

List 3 things you have trouble doing because of your condition:	How limited?			
	Mild	Mild-Mod	Mod-Severe	Severe
1.				
2.				
3.				

Lone Lake Physical Therapy, LLC

NAME_____

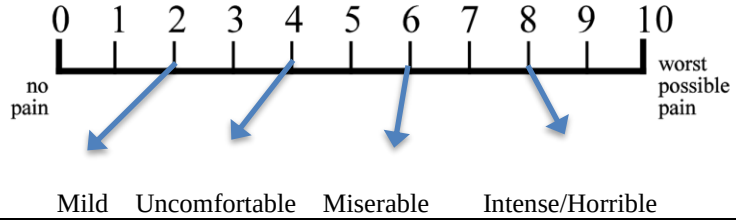
HOW OFTEN ARE YOU IN PAIN?

Frequency of Pain

0%	20%	40%	60%	80%	100%
Never	Occasionally	Often	Most of the time		Always

WHAT IS YOUR CURRENT PAIN LEVEL?

Current Pain Level



What type of pain do you have (sharp, dull, burning, etc)?

_____

Are you taking pain medication? **YES NO**

Have you had 2 or more falls or any falls resulting in injury over the past year? **YES NO**

How often do you use/consume the following?

Tobacco		NEVER	SOMETIMES	DAILY
Alcohol		NEVER	SOMETIMES	DAILY
Recreational Drugs		NEVER	SOMETIMES	DAILY
Coffee		NEVER	SOMETIMES	DAILY
Unhealthy/processed Foods		NEVER	SOMETIMES	DAILY

Lone Lake Physical Therapy, LLC

NAME_____

HEALTH HISTORY

Current	Past	GENERAL
		Implanted Devices
		Neck, shoulder, or arm pain
		Low back, hip or leg pain
		Sleep disturbances, fatigue
		Infections
		Fever
		Sinus
		Headaches
		MUSCULOSKELETAL
		Rheumatoid condition
		Osteoarthritis
		Osteoporosis/Osteopenia
		Scoliosis
		Disc/spine problems
		TMJ
		Cramps/spasms/muscle pain
		Sprains/strains
		Tendonitis
		Bursitis
		CARDIOVASCULAR
		Heart disease
		Blood clots
		Stroke
		Lymphedema/swelling
		High blood pressure
		Low blood pressure
		Irregular heart beat
		Poor circulation
		Chest pain
		Shortness of breath
		Asthma
		COPD
		CANCER (Please list type)

Current	Past	SKIN CONDITIONS (Please list type)
		ALLERGIES (Please list)
		NERVOUS SYSTEM
		Head injuries/concussions
		Dizziness
		Ringing in ears
		Loss of memory/confusion
		Numbness
		Balance issues
		Difficulty walking
		Falls
		Tingling
		Radiating/shooting pain
		OTHER
		Bowel dysfunction
		Gas, bloating
		Bladder/kidney dysfunction
		Abdominal pain
		Incontinence
		Pelvic Floor Issues
		Depression
		Thyroid Dysfunction
		Diabetes
		Pregnancy
		Painful Menses

Please list past surgeries:

Lone Lake Physical Therapy, LLC

NAME_____

Please list your goals for physical therapy/massage:

_____

_____

_____

Other concerns/conditions you would like to discuss with your therapist:

_____

_____

_____

All Current Medications:

***ATTACH LIST IF NEEDED**

Medication name	Dosage	Frequency	Route of administration