901 E. 2nd Ave, Ste 308
Spokane, WA 99202
Phone: 509-481-9363
Fax: 509-408-0891

Patient Information:

First Name: _____MI: _____ Last Name: _____

Address: _____

Apt._____ City: _____State:_____ Zip Code:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Sex: M / F **Date of birth**: _____ Age: ____ Employer: _____

Occupation:_____ E-Mail: _____ ___

Emergency Contact # _____ Name/Relationship_____

Have you had physical therapy in the past? Yes_____ No_____ If yes please answer the following:

When did you receive treatment _____

What diagnosis did you receive treatment for _____

Doctor Information:

Referring Doctor (who wrote the Rx to come to therapy): _____

Referring Doctor Address: _____

Referring Doctor Phone: _____ Fax #_____

Date of the initial Rx: _____

Primary Doctor: _____ Phone _____

Insurance Information:

Primary Insurance

Insurance Co: _____**Ins ID #**_____ Is this the Patient's insurance? ___Yes ___ No If no, the name of the Insured_____

Insured's DOB: _____ Relationship to the patient: ____spouse ____ child ___other

Secondary Insurance

Insurance Co: _____**Ins ID** _____

Is this the patient's insurance? ___ Yes ___ No If not, who is the Insured? Name: _____

Insured's DOB: _____ Insured's relation to the patient: ___ child ___ spouse ___ other

Referred By: _____ How did you hear about us?_____

Patient Authorization Form (Page 1)

Patient Name (printed): _____

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at You Turn Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to You Turn Physical Therapy, LLC and its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize You Turn Physical Therapy, LLC and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

All minors must be accompanied and by an adult who is present during the entire duration of the treatment session.

Initial Here: _____

Assignment of Benefits

I authorize payment directly to You Turn Physical Therapy, LLC., its subsidiaries and/or affiliates for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial Here: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for You Turn Physical Therapy, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial Here: _____

Payment Guarantee

I agree to pay You Turn Physical Therapy, LLC. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of You Turn Physical Therapy, LLC.

Initial Here: _____

Patient or Guardian Signature:	*Date:*

Patient Authorization Form (Page 2)

Patient Name (printed): _____

Office & Financial Policies

-- Please bring all current insurance and claim Information if you did not scan it, as well as photo identification to your initial visit.

-- Insurance coverage is never guaranteed. Your Insurance company determines benefits when claims are received. Any written or verbal information regarding your coverage provided to you by our staff in no way guarantees that your care here will be covered by your insurance company. It is strongly recommended that you personally verify your insurance benefits with your insurance provider prior to receiving care. If your insurance company requires a referral, preauthorization or prescription, it is your responsibility to obtain the referral, preauthorization or prescription from your doctor prior to your appointment.

-- Patents whose care will not be covered in full by insurance are required to make a payment on their account at each time of service. The payment is determined as follows: -- Co-pay amounts set by your insurance carrier are due in full at each visit. -- Patients with an outstanding deductible will pay an estimate of between $160 for the initial evaluation and $100 for additional visits until the deductible is met. -- Patients with a coinsurance, after the deductible has been met, will be charged an estimate of $17 at each visit. -- Payment for supplies are due in full at the time of service. -- Patients without insurance are eligible for our Time of Service Program. Charges must be paid in full at each visit.

-- Any outstanding balance is due within 30 days after the insurance company has paid. If your insurance company does not pay us, the full amount is due within 90 days after the date if service.

-- Account Responsibility: Many people are under the impression that if they have insurance, it is the insurance company that owes You Turn Physical Therapy for their services. This is not the case. The insurance contract is between you and the insurance company; our relationship to you is as a patient to whom we are providing services.

Our responsibility: -- To bill all claims to your insurance carrier(s) in a timely manner on your behalf -- To assist you in resolving any problems with your claim payment

Your responsibility: -- To provide us with current and accurate information to submit your claims correctly -- To keep track of the number of visits allowed, expiration date and the number of visits use, even if those services were performed within another facility or clinic. -- To pay your co-pays, coinsurance or deductible payments at the time of service from us. To pay any additional amount owed as determined by your insurance carrier within 30 days of receipt of your first statement.

-- Any Unpaid accounts past 90 days may be sent to a third-party collection agency and may have an additional 1.5% Interest charge attached. Additional collection fees and/or attorney fees will be your responsibility.

-- $25 processing fee will be added to all returned checks.

-- Your signature below gives us permission to engage in collection of insurance or other 3rd party benefits. You agree to inform our clinic placed on release of your medical records immediately and in writing upon signing any exclusive release of medical records with your attorney, or of any limitation you wish to place on release of your medical records.

-- Your signature below acknowledges that you have been made aware of our notice of privacy practices.

-- Your signature authorizes direct payment to our clinic by your insurance company or other third party provide.

-- Please feel free to ask our Patient Account Manager any financial questions you may have. You may call Becky at 509-481-9363. Our intention is to provide you with the highest level of service and care.

.Initial Here:_____

Credit Card Policy

For optimal treatment time during your session, it is recommended to keep a credit card on file for collecting co-pays and other needed payments at the time of check-in. Currently, our secure system automatically will save your credit card information once used. If this causes you concern, you have the option to let your therapist know at the start of each session so they can manually delete the credit card information or you can write a check. At this time cash is not accepted.

Initial Here: _____

Patient or Guardian Signature:	*Date:*

Patient Authorization Form (Page 3)

Patient Name (printed): _____

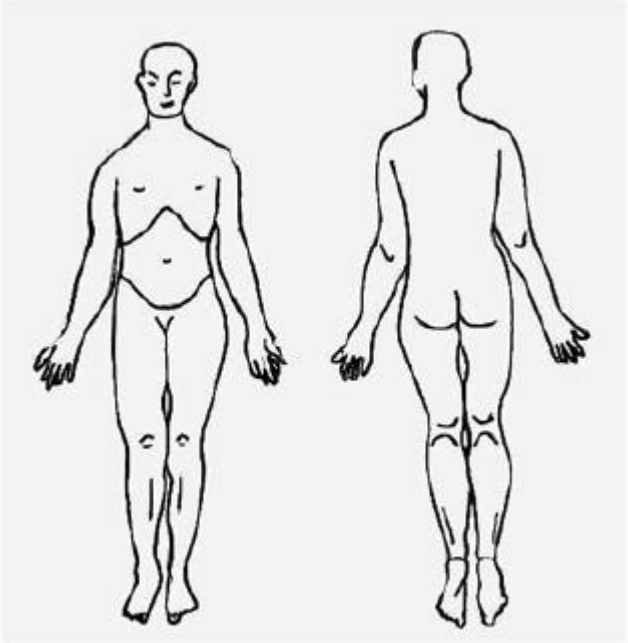
Terms and Conditions
Effective Date: 10/24/25 By opting in to receive SMS messages from You Turn Physical Therapy ("we," "us," "our"), you agree to the following terms: **1. SMS Messaging Service** By providing my phone number, I consent to receive SMS text messages from You Turn Physical Therapy for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg & data rates may apply. Reply HELP for support. Reply STOP to opt out. **2. Message Frequency** You will receive may vary. **3. Message and Data Rates** Message and data rates may apply based on your mobile carrier's terms. **4. Privacy Policy** Your information will be handled in accordance with our Privacy Policy, which can be viewed above or you can request printed copy from the office. **5. Opt-Out Instructions** You can opt out at any time by replying "STOP" to any SMS message. Reply HELP for support. You may also contact us directly at youturnpt@gmail.com or 509-481-9363 **6. Liability** We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers. By opting in, you confirm that you are the owner or authorized user of the phone number provided and that you are at least 18 years old. Initial Here: _____

Patient or Guardian Signature:	*Date:*

Patient Name _____ Date: _____

You Turn Physical Therapy
Physical Therapy Pre-Exam Questionnaire

Please indicate the location of your symptoms on the body diagram below:



Briefly describe your symptoms:

□ Aching □ Constant
□ Sharp/Stabbing □ Intermittent
□ Numbness □ Burning
□ Tingling □ Other _____

On the scale below, circle your WORST pain the last couple of days

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your CURRENT level of pain:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your LOWEST LEVEL of pain:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

What caused your pain/or problem? _____

Approximately when did it start? ____/____/_____

Is it getting worse, better, or staying the same? _____

Have you ever had this pain/problem before? (Circle) YES NO

Are any of your usual everyday activities affected? YES NO
If yes, describe how:

List all past surgeries with dates:

List all medical conditions you have (or were told you have):

*** Please provide a list of all your current medications. (A photocopy of a printed list is acceptable).

_____ _____
Patient Signature Date

Cancellation and No-Show Policy

The following is our policy regarding cancellations and no-shows. We take this subject seriously, because it can make the difference in whether you succeed in your treatment or not. Cancellations, along with no-shows, also decrease our ability to accommodate the scheduling needs of other patients. Your full cooperation is required with the following policy:

- **Cancellations: We require 24 hours notice in the event of a cancellation.** It is your responsibility, when you call in, to have an alternative time in mind that will ensure you receive the prescribed number of treatments that week. If you cancel less than 24 hours in advance, you will be charged our cancellation/no-show rate of $75. If you have more than 2 cancellations within your course of treatment, your physician WILL be notified and you may be discharged from therapy.
- **No Shows:** It is important to be on time to your scheduled appointments. Please call us if you are running late for your appointment so we may plan accordingly. If you are late for your appointment, this will cut into your treatment time which may prevent an effective session from occurring. Again, you will be charged our cancellation/no-show rate of $75 if you do not show for you appointment.
- Please be advised that if you are being charged for the cancellation or no-show, that your insurance will not pay for that fee. You will be billed personally for that amount. You will need to pay that fee before or at your next appointment to be seen again for treatment.
- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments must be forwarded to your Case Manager and Primary Physician and could jeopardize your claim.
- Ensure that you have your preferred means of contact listed so we can provide you with an appointment reminder the day before your session. It is your responsibility to verify the correct appointment time when you get the reminder.
- When you do not show, as scheduled, or use appropriate cancellation procedures for your session, THREE people are hurt:

    - YOU - because you do not get the treatment you need.
    - THE THERAPIST - because they now have a vacant time that was reserved for you personally.
    - ANOTHER PATIENT - because they could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. WE ARE looking forward to working with you.

I acknowledge and understand the above:

_____ _____

Patient/Guardian/Responsible Party Signature Date

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Spokane, WA 99202
P) 509-481-9363
F) 509-408-0891

Office & Financial Policies

Patient Name:_____ Date:_____

- Please bring all current insurance and claim information, as well as photo identification to your initial visit.
- Insurance coverage is never guaranteed. Your insurance company determines benefits when claims are received. Any written or verbal information regarding your coverage provided to you by our staff in no way guarantees that your care here will be covered by your insurance company. It is strongly recommended that you personally verify your insurance benefits with your insurance provider prior to receiving care. If your insurance company requires a referral, preauthorization or prescription, it is your responsibility to obtain the referral, preauthorization or prescription from your doctor prior to your appointment.
- Patients whose care will not be covered in full by insurance are required to make a payment on their account at each time of service. The payment is determined as follows:
    - Co-pay amounts set by your insurance carrier are due in full at each visit
    - Patients with an outstanding deductible will pay an estimate of $160-$180 for the initial evaluation and $100 for additional visits.
    - Patients with coinsurance will be charged $17 at each visit
    - Payment for supplies are due in full at the time of service
    - Patients without insurance are eligible for our Time of Service Program. Charges must be paid in full at each visit.
- Any outstanding balance is due in 30 days after the insurance company has paid. If your insurance company does not pay us, the full amount is due within 90 days after the date if service.
- Account Responsibility: Many people are under the impression that if they have insurance, it is the insurance company that owes You Turn Physical Therapy for their services. This is not the case. The insurance contract is **between you and the insurance company;** our relationship to you is as a patient to whom we are providing services.

Our responsibility:

- To bill all claims to your insurance carrier(s) in a timely manner on your behalf
- To assist you in resolving any problems with your claim payment

Your responsibility:

- To provide us with current and accurate information to submit your claims correctly
- To keep track of the number of visits allowed, expiration date and the number of visits use, even if those services were performed within another facility or clinic.
- To pay your co-pays, coinsurance or deductible payments at the time of service
- To pay any additional amount owed as determined by your insurance carrier within 30 days of receipt of your first statement from us.

- Unpaid accounts past 90 days may be sent to a third party collection agency and may have an additional 1.5% interest charge attached. Additional collection fees and/or attorney fees will be your responsibility.
- A $25 processing fee will be added to all returned checks.
- Your signature below gives us permission to engage in collection of insurance or other 3rd party benefits. You agree to inform our clinic immediately and in writing upon signing any exclusive release of medical records with your attorney, or of any limitation you wish to be placed on release of your medical records.
- Your signature below acknowledges that you have been made aware of our notice of privacy practices.
- Your signature authorizes direct payment to our clinic by your insurance company or other third party provider.
- Please feel free to ask our Patient Account Manager any financial questions you may have. You may call Becky at 509-481-9363. Our intention is to provide you with the highest level of service and care.

By signing below, I acknowledge and understand the policies as stated above and authorize treatment from You Turn Physical Therapy.

Signature of Patient or Legal Guardian:_____ Date:_____