PURSUIT PHYSICAL THERAPY

WELLNESS MAINTENANCE VISIT (WMV)

Appt. Date

PATIENT INFORMATION

Last Name	First	MI	Date of Birth		Male ☐ Female ☐
Home Address	City	State	Zip Code	Home Phone	Cell Phone
Marital Status ☐ Single ☐ Married ☐ Other	Have you been treated at Pursuit Physical Therapy clinic before? If yes, when?				
E-Mail Address			Preferred Appointment Reminder ☐ Call ☐ Email ☐ Text		

REFERRING PHYSICIAN INFORMATION

Last Name	First	MI	Address	Telephone

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

Last Name	First	MI
Address	City / State / Postal Code	
Home Phone	Work Phone	
Relationship ☐ Spouse ☐ Parent ☐ Guardian	Parent or Guardian E-Mail Address	

REASON FOR TODAY'S VISIT

Is this injury/condition related to …

Your Job ☐ Yes ☐ No	An Auto Accident ☐ Yes ☐ No	A Home Accident ☐ Yes ☐ No	Other Accident ☐ Yes ☐ No

Please indicate the date of your accident/injury:	Please indicate the date of your illness (1st symptom):
Please provide name of insurance adjuster or contact:	Telephone

Please describe your injury/accident/illness:

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	Date

Please sign + date ↗

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name		Identification Number		Group Number
Address	City	State	Zip Code	Telephone
Policyholder *(if other than patient)*		☐ Male ☐ Female		Date of Birth
Social Security Number *(of policyholder)*	Telephone *(of policyholder)*			Relationship to Patient
Employer *(of policyholder)*				

SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name		Identification Number		Group Number
Address	City	State	Zip Code	Telephone
Policyholder *(if other than patient)*		☐ Male ☐ Female		Date of Birth
Social Security Number *(of policyholder)*	Telephone *(of policyholder)*			Relationship to Patient
Employer *(of policyholder)*				

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Pursuit Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 2% per month (24% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Pursuit Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Authorized Signature	Date

Please sign + date ↗

PURSUIT P.T.

Manual Physiotherapy

Neal O'Neal P.T.

Wellness Maintenance Visit (WMV)

Pursuit PT offers a cash rate for Wellness/Maintenance Visits.

Guidelines are as follows:

- Cash visits are paid at the time of service. We DO NOT send billing invoices.
- Cash visits are considered a Wellness Maintenance Visit (WMV).
- WMV visits are considered not medically necessary by insurance therefore we DO NOT keep records or chart notes.
- We DO NOT provide any documentation for a WMV
  - No billing records are kept for WMV therefore no invoices are available for dates of service.
  - WMV have no insurance billings codes therefore these cannot be billed to insurance.
- We DO NOT provide a receipt for a WMV
  - If credit card/debit card or cash is used, an email receipt will be sent to your email address.
  - If a check is used, the canceled check from your bank or online banking is your receipt.
- WMV's are nonrefundable. We cannot refund the visit and then bill your insurance. If you want visits billed to your insurance, a new appointment will need to be made with the appropriate billing codes and chart notes, your insurance can review and pay.

I have read and understand the guidelines of the WMV at Pursuit PT.

_____ _____

Signature Date

_____

Print Name

PURSUIT PT 14961 NE 95th Street REDMOND WA 98052
PH 206 856 9305 FAX 425 881 1022