Prouse Physical Therapy LLC

PO Box 921 / 17141 Vashon Hwy SW, Ste 103
Vashon WA 98070
Phone: 206-463-1100 Fax: 206-463-1101
prousephysicaltherapy@comcast.net

Welcome to Prouse Physical Therapy!

Please complete the attached forms and bring to your first appointment.

The office is located in Vashon Town Square, across the street from Ober Park and next door to Bramble House restaurant (where the Chamber of Commerce and Beachcomber are located). We do not have a receptionist so please have a seat in the waiting area (leather chairs and fireplace) and your therapist will come get you.

Helpful Information to find out before your first appointment:

a. Does your insurance require a referral from a physician?
b. How many visits per year are you allowed?
c. Do you need pre-authorization for physical therapy services?
d. Have you met your deductible?
e. What is your co-pay?

Please bring your insurance card and any co-pays, if applicable.

Appointments will be approximately 45 -60 minutes.

We look forward to seeing you soon!

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Patient Information

Name:_____ Date of Birth _____

Billing Address:_____

Telephone: Home_____Cell_____

Email Address: _____

Emergency Contact:_____Phone:_____

Referring Physician:_____Phone: _____

Preferred method of appointment reminder Text_____Phone_____Email _____

Insurance / Billing Information

To assure payment by your insurance company, please confirm you have physical therapy coverage and if you require "prior authorization" for services.

Please check the appropriate box:

_____ I do not have insurance coverage that Prouse Physical Therapy LLC is contracted with, and I agree to pay the out–of–pocket rate of $150 for evaluation, and $130 for any additional treatment sessions.

_____ I am insured with a plan that Prouse Physical Therapy LLC is contracted with and wish to submit claims to my insurance company. I agree that I will be responsible for any co-pays, coinsurance, or deductibles that my plan requires.

Name of insurance:_____ID#_____

Subscriber name:_____Group # _____

If dependent:
Name of primary subscriber:_____Date of birth of primary:_____

If L&I or PIP claims:
Claim #_____Date of injury: _____

Contact person for L&I or PIP Claims:
Name:_____Phone: _____

Patient Signature:_____Date: _____

Financial Agreement:

For Insurance Claims:

The above information is correct to the best of my knowledge. I understand that Prouse Physical Therapy LLC will bill my insurance company for the services provided, and that I am responsible for all deductibles, co-pays, and services not covered by my insurance carrier. I authorize Prouse Physical Therapy LLC to furnish the responsible insurance company and other authorized parties with necessary information to process physical therapy claims on my behalf, and I authorize payment of benefits to the provider of services.

Patient signature:_____ Date: _____

For cash payment:

I am financially responsible for payment of balance due for services provided by Prouse Physical Therapy LLC.

Patient signature:_____ Date: _____

Cancellation policy:

- In the event you need to cancel an appointment, please provide at least 24-hour notice by telephone at (206) 463-1100.
- **Cancellations with less than a 24-hour notice will result in a charge of $50.**
- **No-shows and cancelations within 1 hour of appointment will result in a full charge for the session of $130.**
- Exceptions to this policy may be made at the discretion of Prouse Physical Therapy.

Patient signature:_____ Date: _____

Consent to treatment of a minor:

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

Signature of parent/guardian:_____ Date: _____

Consent to unencrypted email correspondence regarding your care:

I understand the risks of unencrypted email and DO give permission to Prouse Physical Therapy LLC to communicate personal health information with me via unencrypted email to the email address I supplied above. I also agree to receiving appointment reminders via phone or email message.

Patient signature:_____ Date: _____

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Liability Release Form

On this_____day of_____. 2025, intending to be legally bound hereby, the undersigned agrees and does hereby release from liability and to indemnify and hold harmless Prouse Physical Therapy LLC, and any of its employees or agents representing or related to Prouse Physical Therapy LLC, from any and all liability, claims, costs, expenses, injuries and or losses, that I may sustain as a result of my participation in an independent exercise program at above mentioned clinic.

I have carefully read this document, understand its contents, and am fully informed about the program I am to perform independently and am satisfied that I can safely participate in this program. I am aware that this document is a contract with Prouse Physical Therapy LLC. I, or my parents/legal guardian if I am under the age of eighteen, sign it freely and voluntarily.

Patient signature:_____Date: _____

Parent/Legal Guardian Signature:_____Date: _____

Notice of Privacy Practices- Prouse Physical Therapy LLC

THIS NOTICE DESCRIBES JOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Your protected health information (PHI) is information that identifies you and that relates to your past, present or future health condition, the care provided, or the past, present, or future payment for your health care. I will use your PHI for the purposes of treatment, payment, and health care operations.

Treatment includes the disclosure of health information to providers who have referred you to me for care, providers to whom I have referred you, or other providers who have been involved in your care.

Payment includes the disclosure of health information to your insurance company so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at my clinic or for business planning activities.

Other special uses: My practice may use your PHI to contact you by phone, email or mail for scheduling or coordination of care.

Uses and Disclosures Required by Law: The federal health information privacy regulations either permit or require us to use of disclose *Your PHI in the following ways*: I may share some of your PHI with a family member or friend involved in your care if you do not object, I may use your PHI in an emergency situation when you may not be able to express yourself, and I may use or disclose your PHI for research purposes if I am provided with very specific assurances that your privacy will be protected. I may also disclose your PHI when I am required to do so by law, for example, by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

I may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, I may release health information about you when it is determined to be necessary by the appropriate military command authorities. I may also release information about you for workers compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by me for other purposes.

Your Privacy Rights

Restrictions: You have the right to request restrictions on how your PHI is used however; I am not required to agree with your request. If I do agree, I must abide by your request.

Confidential Communications: You have the right to request confidential communications from me at a location of your choosing. This request must be in writing.

Access to PHI: You have the right to request a copy of your medical record. You must make this request in writing, and I may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to request an amendment be made to your PHI, if you disagree with what is said about you. This request must be made in writing. If I disagree with you, I am not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. I may not amend parts of your medical record that I did not create.

Accounting of Disclosures: You have the right to request an accounting of the disclosures I have made of your PHI. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints: If you feel that your privacy rights have been violated, you have the right to make a complaint to me in writing without fear of retaliation. Your complaint should contain enough specific information so that I may adequately investigate and respond to your concerns. If you are not satisfied with my response, you may complain directly to the Secretary of Health and Human services.

Office of Civil Rights
US Department of Health and Human Services
2201 Sixth Ave- mail stop RX-11
Seattle, WA 98121
(206) 615-2290; (206) 615-2296

My duty to Protect Your Privacy: I am required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require me to provide you with this document, my Notice of Privacy Practices. I reserve the right to update this notice if required by law. If I do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from me.

Privacy Contact: If you would like more information about our privacy practices or to file a complaint.

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I have reviewed and I agree to the Privacy Policy of Prouse Physical Therapy LLC

Patient Signature:_____ Date: _____

Prouse Physical Therapy Health Questionnaire

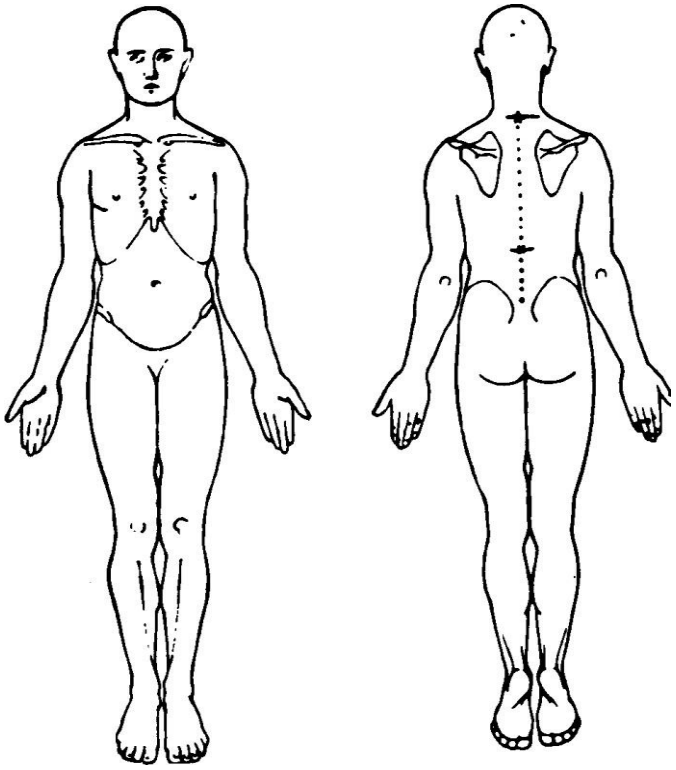
Patient Name_____**Today's Date**_____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

What is your chief complaint? (Diagnosis, symptoms or condition) _____

Date of onset:_____**Date of surgery**:_____**Referred by**: _____

Draw your area of symptoms



Do you now have: (yes/no)

___dizziness / fainting / seizures
___night pain
___numbness / weakness
___shortness of breath
___bowel/bladder control problems
___numbness in the genital area
___are you pregnant
___artificial joints
___unexplained muscle weakness

Have you ever had: (yes/no)

___cancer (type:_____)
___heart problems / pacemaker
___high blood pressure
___diabetes
___rheumatoid arthritis
___tuberculosis / hepatitis / HIV
___osteoporosis
___asthma
___stroke
___chest pain
___fainting or dizziness

Does pain awaken you at night? ☐No ☐Yes Do you smoke?☐No ☐Yes Unexplained weight loss? ☐No ☐Yes
What test have you had for this problems? ☐x-ray ☐MRI ☐CT scan ☐other_____
Have you ever had surgery for this problem? ☐No ☐Yes List other surgeries _____

List medications (dose and frequency) or provide a list: _____

_____

How would you rate your PAIN? (0 to 10: 0 = no pain, 10 = unbearable pain)

Right Now _____ At Best _____ At Worst _____

During the last year: (please circle your response)

a. How many falls have you had? None 1 2 More than 2
b. Have you injured yourself from any of these falls? Yes No
c. Has dizziness been a factor in your fall? Yes No

Patient signature:_____**Date:** _____