Verified: _____ Date: _____ PT: _____ (OFFICE USE)

kitsap physical therapy
AND SPORTS CLINICS

Are you a registered Tribal Member? ☐ **Yes** ☐ **No** **If Yes, which Tribe:** _____

(We ask this question as KPT is contracted directly with some of the local Tribes and we want to ensure you receive your full benefits.)

Last Name _____ **MI** ___ **First Name** _____ **DOB** ___/___/_____

Address _____ **City** _____ **State** ____ **Zip** _____

Cell (_____) _____ **Alt Phone** (_____) _____ ☐ **Male** ☐ **Female** ☐ **Other**

Permission to text appointment reminders ☐ **Y** ☐ **N** **Social Security #** _____-_____-_____

☐ **I hereby give permission for KPT to leave a detailed message on my voicemail/answering machine.**

Email address _____ **Employer:** _____

☐ **I hereby give permission for KPT to send me email messages.**

Emergency contact _____ **Relationship** _____ **Phone** (_____) _____

Injury/Body Part(s) _____ **Date of Injury** ____/___/_____ **Cause** _____

***Referring* Physician** _____ ***Primary Care* Physician** _____

Primary Insurance _____ **Secondary Insurance** _____

Parent Name _____ **Address** _____ **Phone** (____) _____
(If patient is a minor) ***(If different from above)***

☐ **L & I Claim** ☐ **Workers' Comp/Self -Ins Claim** **Date of Injury** ___/___/____ **Claim #** _____

Employer _____

Claim Manager's Name _____ **Phone** (____) _____

☐ **Motor Vehicle Accident** **Date of Accident** ____/____/_____ **State accident occurred** _____

Your Car Insurance Company _____ **Available P.I.P.?** ☐ **Y** ☐ **N**

Adjuster's Name _____ **Phone** (_____) _____

☐ **I will request a copy of the Notice of Privacy Practices at check-in.**
☐ **I have been offered a copy of the Notice of Privacy Practices, but have chosen to decline.**
☐ **I hereby give permission for KPT to discuss my medical information with** _____

Consent for Treatment, Assignment of Benefits, & Release of Information: *I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.*

Signature _____ **Date** _____
(Parent or Guardian, if patient is a minor)

Revised: 12/18/2025

FINANCIAL POLICY

For over 45 years: KPT has been committed to helping patients of all ages return to daily life enjoyment. To continue providing high-quality care and supporting our team, we maintain the following financial policy.

Insurance Responsibility. Your insurance policy is a contract between you and your insurance provider. As a courtesy, we will bill your insurance when accurate information is provided; however, coverage, payment amounts, and denials are determined solely by your plan. You are ultimately responsible for all charges for services rendered. We cannot negotiate or waive patient responsibility set by your insurance contract.

Medicare. Medicare establishes an annual outpatient therapy financial threshold. After your deductible is met, Medicare pays 80% of the allowed amount; the remaining 20% is the patient's responsibility and cannot be waived. Please notify us if you have received therapy services elsewhere during the calendar year.

Referrals. Some insurance plans require a physician referral, while others allow direct access. It is your responsibility to ensure that any required referral is obtained. Charges denied due to a missing or invalid referral become the patient's responsibility.

Payment Policy. We strongly encourage patients to keep a credit or debit card securely on file. Based on information provided by your insurance plan, we will attempt to estimate your deductible, co-pay, or co-insurance; however, estimates are not a guarantee of coverage or payment. Payment of your estimated out-of-pocket responsibility is expected at the time of each visit. Payment plans may be arranged with our billing team; failure to comply with agreed terms may result in the full balance becoming immediately due. Accounts that become past due may be referred to collections. If a patient balance reaches $500 or more, appointments may be paused until the balance is reduced below $500 or a payment arrangement is established.

Billing Dept. Questions - arranging payment plans: Monday–Friday, 8:00 AM–5:00 PM | (360) 779-5732

Cancellation / No-Show Policy. To allow access for other patients, we require timely notice of cancellations: 24 hours for Monday–Thursday appointments, or by 5:00 PM Friday for Monday appointments. Several late cancellations or any no-show will result in a $60 fee (not billable to insurance). Patients with repeated missed appointments may be moved to same-day scheduling only.

Remote Therapeutic Monitoring (RTM). When covered by insurance, RTM will be incorporated into your care as it has been shown to speed recovery and improve outcomes. Depending on your plan, a co-pay or monthly cost-share may apply. Participation and related text communication are optional and may be discontinued at any time by letting a KPT team member know.

Text Messaging. By providing your mobile number, you consent to receive text messages from Kitsap Physical Therapy, which may include personal health information. Standard messaging rates may apply.

Financial Responsibility Acknowledgment. I understand that I am financially responsible for all charges for services provided by Kitsap Physical Therapy & Sports Clinics. I understand that insurance benefit estimates are not a guarantee of payment and agree not to delay or withhold payment if my insurance denies any portion of my claim.

Signature: _____ Date: _____ Printed Name: _____

Witness Initials: _____