

PATIENT REGISTRATION

FOR OFFICE USE
Acct #:
ICD-9:

PATIENT INFORMATION

Name <i>(Last, First, MI)</i> :		Date:
Address:		Phone:
City, State, Zip:		Alt. Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other		E-mail:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate:	Soc Sec #:
Referred to this office by:		Primary Care Physician:
Patient's Employer:		Spouse's Name:
Address:		Spouse's Employer:
City, State, Zip:		Spouse's Work Phone:
Occupation:		Spouse's Occupation:

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Insurance Address:		Subscriber's Name:	
Insurance Phone:		Subscriber's Date of Birth:	
Group#:	ID#:	Group#:	ID#:
Subscriber's Name:		Subscriber's Name:	
Subscriber's Date of Birth:		Subscriber's Date of Birth:	
Subscriber's Employer:		Subscriber's Employer:	
Subscriber's Soc Sec #:		Subscriber's Soc Sec #:	
Subscriber's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian		Subscriber's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	

INJURY INFORMATION

Injured at: <input type="checkbox"/> Home? <input type="checkbox"/> School? <input type="checkbox"/> Work? <input type="checkbox"/> Auto Accident? <input type="checkbox"/> Other:			
Injury date:	Claim #:	Injury date:	Claim #:
Work Related Injury		Auto Accident	
Insurance:		Insurance:	
Adjustor:		Adjustor:	
Adjustor's Phone:		Adjustor's Phone:	
Adjustor's Fax:		Policy Holder:	

EMERGENCY INFORMATION

In Case of Emergency, Please Contact:	
Name:	Relation:
Phone:	Work Phone:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim.

Signed: X _____

**EDMONDS PHYSICAL THERAPY
& SPORTS REHABILITATION P.S.**

PATIENT HEALTH HISTORY

PATIENT NAME: _____ AGE: _____ OCCUPATION: _____

DIAGNOSIS / REASON FOR PHYSICAL THERAPY: _____

PLEASE CHECK IF YOU HAVE SOUGHT CARE FROM ANY OTHER MEDICAL PROVIDERS FOR THIS PROBLEM:

◇ E R ◇ Medical Specialist ◇ Massage ◇ Acupuncture ◇ Chiropractor ◇ PT/OT ◇ Other _____

Due to recent changes in federal healthcare regulations, please answer these following questions

Is this treatment related to: Workers Compensation Claim (Y)(N); Litigation (Y)(N)

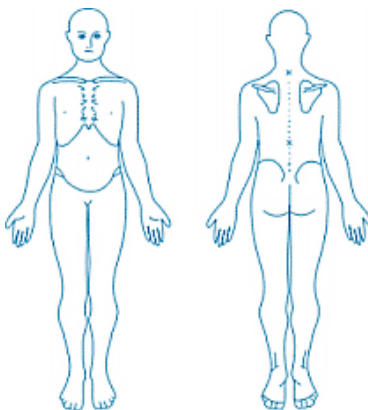
RECENT DIAGNOSTIC TESTS: ◇ X-ray ◇ MRI ◇ CT scan ◇ Bone Scan ◇ Blood Tests ◇ EMG ◇ Other _____

PLEASE RATE YOUR **PAIN** ON THE FOLLOWING SCALE (0 = NO PAIN AND 10 = WORST PAIN POSSIBLE):

Your pain: **RIGHT NOW:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

LOWEST ← → HIGHEST: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PLEASE INDICATE WHERE YOUR PAIN / SYMPTOMS ARE LOCATED:



PATIENT SPECIFIC FUNCTIONAL SCALE

Please list 3 important activities that you are unable to do or are having difficulty doing as a result of your condition:

<u>Please List 3 Activities</u>	<i>(Unable)</i>	<u>Please Rate Your Ability to Perform Your Activities</u>	<i>(No Limitation)</i>
1. _____	0	1 2 3 4 5 6 7 8 9 10	
2. _____	0	1 2 3 4 5 6 7 8 9 10	
3. _____	0	1 2 3 4 5 6 7 8 9 10	

PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS:

MEDICATION	DOSAGE	REASON FOR TAKING

MEDICATION	DOSAGE	REASON FOR TAKING

PLEASE LIST ANY ALLERGIES: _____

PLEASE CHECK ANY PAST OR PRESENT CONDITIONS

PLEASE ANSWER THESE SPECIFIC QUESTIONS WITH A "✓" MARK			
	NEVER	PAST	PRESENT
AUTO – IMMUNE			
Fibromyalgia / Chronic Fatigue			
Gout			
Lupus			
Lyme Disease			
Multiple Sclerosis			
Rheumatoid Arthritis			
CANCER			
Any Type: _____			
NEUROLOGIC			
Numbness/Tingling Legs			
Weakness Legs			
Bowel/Bladder Abnormalities			
Infections			
Recent Weight Loss or Gain			
		PAST	PRESENT
CARDIOVASCULAR			
Chest Pain / Angina			
Heart Disease / CAD			
Heart Attack / MI			
Heart Murmurs / Palpitations			
High Blood Pressure			
Pacemaker			
ENDOCRINE / METABOLIC			
Diabetes / Hypoglycemia			
Thyroid Dysfunction			
GASTROINTESTINAL			
Acid Reflux			
Colitis / Diverticulitis / IBS / Crohn's			
Ulcers			
IMMUNOLOGIC / INFECTIOUS DISEASE			
Hepatitis A, B, or C			
Herpes			
HIV / AIDS			
Shingles			
Tuberculosis			

NEUROLOGIC II	PAST	PRESENT
Coordination Difficulties /Falling		
Numbness/Tingling Arms		
Weakness Arms		
Vertigo/Ringing in Ears/Dizziness		
Headaches		
Parkinson's		
Seizure Disorder / Epilepsy		
Stroke / TIA		
Head Injury/Concussions		
PULMONARY		
Asthma		
Chronic Cough		
COPD / Bronchitis / Emphysema		
Shortness of Breath		
VASCULAR / BLOOD DISORDERS		
Anemia		
Bleeding or Clotting Disorders		
Deep Vein Thrombosis (DVT)		
Peripheral Vascular Disease (PVD)		
Swelling of Hands or Feet		
Varicose Veins		
MUSCULOSKELETAL		
Fracture /Dislocation		
Metal Implants / Pins		
Osteoporosis		
Sprain / Strain		
Tendonitis / Bursitis		
GENERAL / OTHER		
Alcohol / Substance Abuse		
Fainting, Lightheadedness		
Hernia		
Kidney Problems		
Liver Disease		
Pregnant		
Smoke		
Vision Difficulty / Glasses / Contacts		
OTHER (please fill in):		
MENTAL HEALTH		
Depression		
Anxiety		
Bipolar / Schizophrenia / PPD		

SURGERIES OR HOSPITALIZATIONS (past or recent): _____

To the best of my knowledge, the information above is complete and accurate.

Patient / Guardian Signature: _____ Date: _____

Thank-you!!

EDMONDS PHYSICAL THERAPY & SPORTS REHABILITATION, P.S.
7315 212TH Street SW, Suite 104-Edmonds, WA 98026 (425) 774-3226

CLINIC POLICIES

I, the undersigned, hereby authorize Edmonds Physical Therapy and Sports Rehabilitation, P.S. to receive the benefits to which I, or my dependents are entitled to under my health insurance plan. **I understand that all fees are my responsibility**, and I will pay Edmonds Physical Therapy and Sports Rehabilitation, P.S. the full amount due after my insurance company has processed claims. Should the account exceed an amount that I am able to pay in full; a payment plan between the undersigned and the clinic can be established. All accounts 90 days past due and without an agreed upon payment plan in current standing will be referred for collections. The undersigned shall pay all reasonable collection expenses including interest on the unpaid balance at 1.0% per month from the date of service, and/or reasonable attorney fees and court costs.

COPAYMENTS: All patients that have a co-payment agreement with their insurance company are required to pay their co-payment amount at the time of each appointment.

APPOINTMENT CANCELLATION: We require 24-hour notice for appointment cancellations. When canceling an appointment, the patient is expected to have an alternate time/day in mind to reschedule the appointment. This allows that the proper number of treatment sessions be attended, per your physician's order. When rescheduling, it may be necessary to schedule with another staff therapist. Repeated appointment cancellations will result in a \$35 fee assessed to your account. This fee is due prior to your next scheduled appointment.

LATE ARRIVALS: In consideration of other scheduled patients, should you arrive more than 10 minutes late for your scheduled appointment time, you may be required to reschedule your appointment.

\$35.00 FEE FOR MISSED APPOINTMENTS: Your insurance company will not cover this fee. You will be responsible for payment of this fee before your next scheduled appointment. Please understand that during your course of treatment, you will experience changes in the amount of your discomfort. Initially there could be some additional soreness before your condition begins to resolve, or you may notice a sudden reduction in your pain. In either situation, it is important that you **keep your scheduled appointments** so that we may further treat your condition until it is resolved, and you have been adequately educated in future prevention/care.

INSUFFICIENT BILLING INFORMATION: You are expected to notify us of changes to your personal contact, or insurance, information. We will bill your insurance for you, provided you supply us with accurate billing information. Ultimately, you are responsible for all charges incurred with us. If you should arrive for your first scheduled appointment with a lack of necessary billing information, you may be required to reschedule the appointment for a time when you are able to provide the required billing information.

SECONDARY INSURANCE BILLING: If we have a current contract with your secondary insurance, we will bill them for you, **one time only**, as a courtesy and a convenience to you. Any balance left unpaid by your secondary insurance is patient responsibility.

\$20.00 FEE FOR 'INSUFFICIENT CHECKING FUNDS': This fee will be assessed to your account for each check returned for insufficient funds. You will be responsible for payment of this fee, as well as the amount of the original 'insufficient funds' check before your next scheduled appointment.

I, the undersigned, authorize the release of all pertinent information contained within my medical records which may be necessary to process this claim for insurance benefits.

Signature by patient/guarantor authorizes Edmonds Physical Therapy and Sports Rehabilitation, P.S. to render service and guarantees payment by the responsible party.

Patient/Guarantor Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

EFF. DATE: 10/01/2002

Revised: 10/01/2011

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have questions, please contact SHAWN D. CATES, PT @ (425) 774-3226.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you, as well as any information we receive in the future. A current copy of this notice will be posted in the office. Copies of this notice are available upon request.

To comply with legal requirements, as well as to provide you with quality care, it is necessary for us to create a record of the care provided to you in this office. These records may also contain information regarding your medical history, personal, financial, and insurance information. These records are retained for seven years. After seven years they are destroyed.

WE ARE REQUIRED BY LAW TO:

- Make sure that medical information that identifies you is kept private.
- Give you notification of our privacy practices with respect to your medical records.
- Follow the terms of this notice that is currently in effect.

Use and disclosure of your medical information

- To assure quality in your continuum of care, we may disclose medical information about you to other health care professionals, claim managers, or healthcare oversight representatives who are, or will be, involved in taking care of you.
- We may use and disclose medical information about you, as required, so that the services you receive in this office may be billed, and payment for those services may be collected from the responsible party. You are responsible for notifying us of changes to your address or insurance information.
- We will disclose your medical information when required to do so by Federal, State, or Local Law.
- We may disclose medical information about you if necessary to prevent a serious threat to your health and safety or to that of any other person.
- We may release information about you as required by military command authorities.
- We may release information about you in response to a court order, subpoena, or the like.
- We may release information about you if requested by authorized law enforcement officials, coroners, and medical examiners, or by federally authorized personnel such as national security and intelligence officials, or protective services for government officials.

Your rights to your medical information

- You have the right to inspect your medical records. You have the right to obtain copies of your records. To do this, contact the Medical Records Clerk. The clerk will ask that you sign an Authorization for Release of Medical Records, and will inform you of the fees for this service.
- You have the right to amend your records. If you believe there is incomplete or incorrect information in your records, you may submit to our office staff personnel, your amendments in writing, signed and

dated by you. Your amendments will become a permanent addition to your records and will be used and disclosed as previously outlined.

- You have the right to request a history of disclosures of your records for disclosures, on or after April 14, 2003, and other than for permitted purposes as previously outlined. To do this, contact our Medical Records Clerk.
- You have the right to request a restriction or limitation on the information we use or disclose about you. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** If we do agree, we will comply with your request except in the event of an emergency situation requiring release of the information. Submit your request in writing to our office staff personnel. Your request must include what information you want limited; whether you want to limit use, disclosure, or both; and to whom the limit applies.
- You have the right to request that we contact you in a certain way or at a certain location. This request may be given, in writing to any of our office staff personnel.
- You have the right to obtain a copy of this notice. You may verbally request a copy of this notice at any time from our office staff personnel.

Uses and disclosures of your medical information not covered by this notice or by the laws that apply to us will only be made with your written permission. After you have provided us this permission, you may revoke it, in writing, at any time. We will then no longer release information about you for the reasons covered by that written authorization. We, of course, are unable to take back any disclosures that were made with your permission.

If you believe your privacy rights have been violated, you may submit a complaint, in writing to

EDMONDS PHYSICAL THERAPY & SPORTS REHABILITATION, P.S.

ATTN: SHAWN D. CATES, PT

7315 212TH ST SW, SUITE 104

EDMONDS, WA 98026

There are no penalties for filing a complaint.

PRIVACY CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. The terms of our notice may change. Current copies are available upon request.

You have the right to request that we restrict the use and disclosure of your protected health information. We are not required to agree to this request, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of your protected health information as outlined in our Notice of Privacy Practices. You have the right to revoke this consent, in writing, understanding that we cannot take back disclosures that have already been made on your prior consent.

PATIENT NAME: _____

PATIENT / GUARDIAN SIGNATURE: _____

DATE: _____

HIPAA laws limit our ability to discuss your private information with your family members, or other persons close to you.

If you would like to grant us permission to speak with a person other than yourself regarding your protected health information, please indicate by completing the following:

Their name: _____

Relationship to you: _____

Their birthdate: _____

- Additional names may be listed on the back of this form.

Would you like to grant us permission to leave detailed messages on your voice mail or other phone answering system? (Examples may include appt. verification, problems regarding your insurance coverage, account issues, etc.)

- Yes, permission granted. Please leave detailed messages for me.
- No, permission denied. Please leave 'name & number' messages and I (the patient or guardian) will return your call.

FOR EMPLOYEE USE:

This information re-verified/updated:

Initial & Date _____ Initial & Date _____ Initial & Date _____ Initial & Date _____

- Additional names of persons that I grant Edmonds Physical Therapy employees permission to speak with regarding my protected health information.

Their name: _____

Relationship to you: _____

Their birthdate: _____

Their name: _____

Relationship to you: _____

Their birthdate: _____

Their name: _____

Relationship to you: _____

Their birthdate: _____

Their name: _____

Relationship to you: _____

Their birthdate: _____