|  |
| --- |
| PATIENT INFORMATION  |
| **LAST NAME** | **FIRST** | **MI** | **DATE OF BIRTH** | **SOCIAL SECURTIY NUMBER** | **PRONOUNS**  ** HE/HIM** ** SHE/HER** ** THEY/THEM** |
| **ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **HOME PHONE CELL PHONE** **( ) ( )** | **HOW WOULD YOU LIKE TO RECIEVE YOUR REMINDER CALLS?** ** PHONE CALL**  ** TEXT MESSAGE** |
| **MARITAL STATUS** | **E-MAIL ADDRESS** |
| **SINGLE MARRIED DIVORCED OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **EMPLOYMENT STATUS**** EMPLOYED  FULL TIME STUDENT  PART TIME STUDENT  N/A**  | **EMPLOYER NAME/SCHOOL NAME** | **TITLE/POSITION** |
|  |
| REFERRING PHYSICIAN INFORMATION |
| **LAST NAME** | **FIRST** | **MI** | **ADDRESS** | **TELEPHONE** |
| Date you were last seen by your referring physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION |
| **LAST NAME** | **FIRST** | **MI** |
| **ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **HOME PHONE** | **WORK PHONE** |
| **RELATIONSHIP****PARTNER/SPOUSE PARENT GUARDIAN OTHER \_\_\_\_\_\_\_\_\_\_\_\_** | **PARENT OR GUARDIAN E-MAIL ADDRESS** |
|  |
| REASON FOR TODAY’S VISIT |
| **IS THIS INJURY/CONDITION RELATED TO YOUR …** |
| **JOB****YES NO**  | **CAR****YES NO**  | **HOME****YES NO**  | **OTHER ACCIDENT****YES NO**  |
| **PLEASE INDICATE THE DATE OF ACCIDENT OR INJURY** | **PLEASE INDICATE THE DATE OF ILLNESS (1ST SYMPTOM)** |
| **PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT** | **TELEPHONE** |
| **PLEASE DESCRIBE INJURY/ACCIDENT/ILLNESS:** |
|  |

|  |
| --- |
| PRIMARY INSURANCE COMPANY INFORMATION |
| **PRIMARY INSURANCE COMPANY NAME** | **IDENTIFICATION NUMBER OR CLAIM #** | **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 INFORMATION |
| **SECONDARY INSURANCE COMPANY NAME** | **IDENTIFICATION NUMBER OR CLAIM #** | **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)** |
| **For Labor & Industries and MVA patients only:**Claim manager’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim manager’s phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT** |
| **\*\*\*** Our clinic has multiple practices including Renew Physical Therapy, Stillwater Massage and Integrative Musculoskeletal Medicine and Wellness. All practices will be referred to as “The Clinics” **I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO THE CLINICS 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 REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THE DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY’S FEES, AND ALL COURT CONTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1% PER MONTH (12% 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 THE CLINICS 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**X | **DATE** |

**Notice of Patient Information Practices**

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

*Our clinic has multiple practices including Renew Physical Therapy, Stillwater Massage and Integrative Musculoskeletal Medicine and Wellness. All practices will be referred to as “The Clinics”*

**THE CLINICS LEGAL DUTY**

The Clinics is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and the following information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

The Clinics uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, The Clinics may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

The Clinics may also use or disclose your health information without prior authorization for public health purpose, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, The Clinics policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

The Clinics may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT’S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information, treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. The Clinics will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that The Clinics may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on The Clinic’s health information practices, or if you have a complaint, please contact the following office:

**HIPPAA Compliance Office**

**The Clinics**

**5620 Rainier Ave South, Suite 102**

**Seattle, WA 98118**

**P: (206)535-8061**

**F: (206)535-8064**

**EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM**

**PATIENT INFORMATION CONSENT FORM**

*Our clinic has multiple practices including Renew Physical Therapy, Stillwater Massage and Integrative Musculoskeletal Medicine and Wellness. All practices will be referred to as “The Clinics”*

I haveread and fully understand The Clinics notice of Information Practices. I understand that The Clinics may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that The Clinics will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Clinic’s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Printed Name*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient Signature*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date*

*REQUEST SIGNATURE FROM EVERY PATIENT*

**CANCELLATION, NO SHOW & DISCHARGE POLICY**

*Our clinic has multiple practices including Renew Physical Therapy, Stillwater Massage and Integrative Musculoskeletal Medicine and Wellness. All practices will be referred to as “The Clinics”*

**Dear Patient:**

Please realize that your physical therapy is your responsibility and we take your care very seriously.

Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job.

* *We require 24 hour 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 get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given in two sequential days.)*
* *There is a $50.00 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally and is due before you next scheduled visit.*
* *If you are more than 20 minutes late, we may not be able to fit you in due to the inconvenience to the other patients and therapist’s schedule. Therefore, the cancellation fee may apply.*
* *We reserve the right to discharge from care those who cancel 3 times within a month even if 24 hours of notice is given when canceling.*
* *For our Workers Compensation patients, by law we are required to report any missed visit to your claims representative. Failure to attend your scheduled visits may jeopardize your status with your insurance plan.*
* *Please understand that your pain may increase and decrease during the course of treatment before it is finally erased.  Before canceling your appointments because of pain, please consult with your therapists.*
* *When it comes time to discharging you from treatment, it is essential that we do so in person. This is very important for our quality assurance, and so that the referring physician is notified of your progress toward discharge goals established by you and your therapist.*

When you don’t show as scheduled, three people are hurt: ***You*** because you don’t get the treatment you need as prescribed by the doctor and/or PT; ***the therapist*** who now has a space in their schedule since the time was reserved for you personally; and ***another patient***who could have been scheduled for treatment if you had given proper notice.

We thank you for your cooperation.

I have read The Clinic’s cancellation policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Signature Date*

**PATIENT HISTORY**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female\_\_\_\_\_\_ They\_\_\_\_\_ Male\_\_\_\_\_\_ Ze\_\_\_\_\_Decline to Answer\_\_\_\_\_

Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPLAINT AND PRESENT ILLNESS:

Area of injury/symptoms Date your symptoms/injury started\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis from your doctor ­ Date of your next doctor recheck \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently off work because of this problem no yes; if yes, last day worked?



Using the diagram, circle the specific area of pain. If pain travels, draw arrows.

Please RATE your pain level. No pain 1 2 3 4 5 6 7 8 9 10 Worst pain.

Pain level at your WORST\_\_\_\_\_ BEST\_\_\_\_\_\_ and AVERAGE\_\_\_\_\_

Please DESCRIBE your pain by circling the word or words below?

dull ache\_\_\_\_\_\_\_ burning heavy sore\_\_\_\_\_

deep ache throbbing twinge other\_\_\_\_\_

stabbing squeezing cramp\_\_\_\_\_\_

nagging drawing sharp\_\_\_\_\_\_\_

Are your symptoms intermittent or constant? (circle one)

Do you have any numbness/tingling/weakness? Where?

Prior to this onset, were you free of these symptoms? Yes\_\_\_\_\_ No\_\_\_\_\_ Explain

What eases the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any other treatment for this problem? What? Chiropractic \_\_\_ Physical Therapy\_\_\_ Other \_\_\_

Did it help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are getting better, getting worse or staying the same? (circle one)

Have you had x-rays? yes no Findings?

Have you had an MRI? yes \_\_\_\_\_\_\_\_ no \_\_\_\_\_\_\_ Findings?

Please list any other tests you have received:

*Women only*: Are you pregnant? yes no Which trimester? 1 2 3

Any other concerns or health changes since the start of this injury/illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACTIVITIES OF DAILY LIVING: Circle activities that are difficult for you and then check the appropriate box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | no difficulty | with difficulty/pain | cannot perform |
| Personal hygiene: hair, bathing, toilet |  |  |  |
| Dressing: zippers/buttons, upper body, lower body, shoes |  |  |  |
| Household chores: reach overhead, lifting/carrying, dust vacuuming, mopping, Meal Preparation: use stove, do dishes |  |  |  |
| Yard/Garden: mowing, tilling, weeding, raking, watering |  |  |  |
| Walking: stairs, curbs, incline, decline, uneven ground, distancesTransportation: Drive self, ride with others, bus, taxi, shopping |  |  |  |

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem):

GENERAL MEDICAL:

Have you EVER been diagnosed as having any of the following conditions?:

|  |  |
| --- | --- |
| A. Cancer YES | K. Other arthritic problems YES |
|  If YES, describe what kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | L. Depression YES |
| B. Heart problems YES | M. Hepatitis YES |
| C. High blood pressure YES | N. Tuberculosis YES |
| D. Asthma YES | O. Stroke YES |
| E. Emphysema YES | P. Kidney disease YES |
| F. Chemical dependency (i.e. alcoholism) YES | Q. Anemia YES |
| G. Thyroid problems YES | R. Epilepsy YES |
| H. Diabetes YES | S. Insomnia YES |
| I. Multiple Sclerosis YES | T. Constipation/diarrhea YES |
| J. Rheumatoid arthritis YES | U. Skin Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you

here, please describe for what reason:

Please list any SURGERIES you have had or any INJURIES for which you have been treated (please include approximate dates):

Please list ALL PRESCRIPTION and/or OVER-THE-COUNTER medications you are currently taking for this and any

other condition (including pills, injections, and/or skin patches):

Do you have allergy to any medications? If yes, please list them:

GOALS: Please list your personal goals for therapy: