Renew Physical Therapy wants all our patients to have the best opportunity at recovery. Your best chance at full recovery is to make the most out of your treatments, attend all scheduled visits in the plan of care and arrive on time.

Please read our policy and sign at the bottom indicating you understand our expectations.

1. **We will begin your treatment sessions on time**, so we need you to **arrive 5 minutes prior** to your appointment time, dressed for your session, and ready to begin at your scheduled time.

2. **If you're running late, we need you to call as soon as you know you will not arrive on time.** If you are **more than 15 minutes late**, your session may need to be rescheduled and our missed visit policy will apply at that time.

3. **If you are sick at any time during care, we need you to call us as soon as you have symptoms**. Please don't wait for the day of your appointment.
   a. Example: If you are sick on Monday but your appointment is Wednesday, call us on Monday.

4. **If you need to cancel or change an appointment, for any reason, call us by 12pm (noon) of the business day before your appointment.** This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
   a. You need to call us at (206) 535-8061 opt 1 to change any appointments. **We do not accept texts or emails to cancel or change appointments.** When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
   b. **You will be charged a $50 missed visit fee for no-shows or cancellations without the required notice.** This fee is due at the time of your next service.

5. **Patients who have multiple no-shows or same-day cancellations will be removed from the active schedule and placed on our day-to-day list** to avoid future last-minute cancellations that keep other patients from care.

6. **For our Workers Compensation patients,** by law we are required to report any missed visit to your claim's representative. Failure to attend your scheduled visits may jeopardize your status with your claim and/or time loss payments.

Please keep in mind that one patient's late (or lack of) notice for appointment changes or cancellations, keeps other patients from getting the care they need and deserve. Our goal with our Missed Visit Policy is to ensure all patients get back to the activities they love as quickly as possible.

This policy has been reviewed with me and by signing below I am indicating that I understand this policy.

______________________	______________________	____________
Patient Signature	Patient Name	Date

NOTICE OF PRIVACY PRACTICES

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 any questions about this notice, please contact Renew Physical Therapy at (206)535-8061 This notice describes Renew Physical Therapy and that of:

- Any health care professional authorized to enter information into your chart.
- Any member of a volunteer group we allow to help you while you are at our practice.
- All employees, staff and other practice personnel.
- All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

RENEW PHYSICAL THERAPY'S LEGAL DUTY
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by Renew Physical Therapy, whether made by your therapists or others working in this office.
This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
Washington State Law under the Uniform Health Care Information Act (Washington Rev. Code Ann. Section 70.02.005 et seq.) governs a patient's right of access to their healthcare information maintained by a healthcare provider.
We are required by federal law (the Health Insurance Portability and Accountability Act of 1996, or HIPAA) to

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.
For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other therapists, assistants, and/or students who are involved in taking care of you in our practice. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
For Payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your care received so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who our specific patients are.
Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.
Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.
As Required by Law: We will disclose medical information about you when required to do so by federal, state, or local law. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medial information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT'S INDIVIDUAL RIGHTS
Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care.
Usually, this includes medical and billing records.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Renew Physical
Therapy. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. Medical records copying fees will be at the standard rate**.** You will receive your copy within 14 days of receipt of your request.
Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.
Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medial information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had to your spouse.
To request restrictions, you must make your request in writing to Renew Physical Therapy. In your request, you must tell us (1) what information you want to limit: (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Renew Physical Therapy.

CHANGES TO THIS NOTICE
Renew Physical Therapy may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Privacy Practices at any time.
CONCERNS AND COMPLAINTS
If you are concerned that Renew Physical Therapy 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, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact:
Renew Physical Therapy ATTN: Office Manager
5620 Rainier Ave South, Suite 102
Seattle, WA 98118 P: (206)535-8061 F: (206)535-8064

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

PATIENT INFORMATION CONSENT
I have read and fully understand Renew Physical Therapy Notice of Privacy Practices. I understand that Renew Physical Therapy 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 Renew Physical Therapy 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 Renew Physical Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying Renew Physical Therapy in writing at any time.

____

Patient/Guarantor Signature ***Date***

CONSENT AND PAYMENT

Consent for Treatment

I consent to treatment procedures and patient care which, in the judgment of my therapist may be considered necessary or advisable while a patient at Renew Physical Therapy.

Renew Physical Therapy may need to contact your health care provider for additional information regarding your diagnosis or treatment. I understand that I have the right to request restrictions on uses and disclosures of protected health information for treatment, payment and health care operations purposes. If such information is withheld by me, I understand that physical therapy treatment may need to be withheld.

I understand that information about physical therapy diagnosis and treatment will be sent to the referring health care provider. This information can be sent to any of my other health care providers should my physical therapist and I deem it necessary and useful.

Insurance Policy

I understand billing my insurance is a courtesy provided to me from Renew Physical Therapy at no additional cost and does not relieve my financial responsibility. I agree that Renew Physical Therapy may furnish the responsible insurance company, and others authorized parties, with necessary information to process physical therapy claims on my behalf in a timely manner.

Co-payments are due at check-in prior to seeing the therapist. If you schedule more than one visit in a week, you may pay in advance for the entire week's co-pays. If you are responsible for a quoted percentage or you have a deductible that has not been met, you will be informed of this. Payment can be made by either debit card, check, HSA or FSA card.

I understand my insurance may have specific limits or restrictions for physical therapy/rehabilitation services and it is my responsibility to be aware and to monitor these limits. I understand I am responsible for all deductibles, co-pays and services not covered by my insurance carrier. If I choose to continue past these limitations, I do understand that I will be responsible for all such visits and balances that go beyond my policies limitations, unless otherwise approved by Renew Physical Therapy and my insurance company. I understand that I am responsible for any unpaid balance. I also understand a 1% (12%APR) finance charge may be assessed to my account if a balance remains unpaid after 60 days.

Most insurance companies have a contracted rate of reimbursement for physical therapy plus a co-payment or patient payment responsibility. Each insurance or third-party payer is different, and benefits vary. We will attempt to contact your company prior to providing services, so that you have an estimate of your benefit coverage. This estimate is not a guarantee of your benefit coverage.

Private Pay / No Insurance

Full payment is due at the time of service. A discount will be applied for payment in full on the day of the appointment.

I have read the above, understand, and agree to its terms.

____

Patient/Guarantor Signature ***Date***

You will be provided with a copy of this form for your records upon request.

PATIENT HISTORY

LAST NAME	LEGAL FIRST	DATE OF BIRTH	SOCIAL SECURTIY NUMBER	PRONOUNS ☐ HE/HIM ☐ SHE/HER ☐ THEY/THEM ☐ DECLINE ☐ Not Listed: __________
ADDRESS		CITY	STATE	ZIP CODE
EMAIL		PHONE	How would you like to receive curtesy appointment reminders?	☐ PHONE ☐ TEXT

EMERGENCY CONTACT: ____ RELATIONSHIP: _________________ PHONE: _______________________

How did you hear about us? ☐Social Media ☐Ad ☐Doctor Referral ☐Google Search ☐Friend/Family ☐Neighborhood ☐Returning Patient ☐Insurance

Referring Physician Information:

First Name:	Last Name:	Location/Phone #:

CHIEF COMPLAINT AND PRESENT ILLNESS:

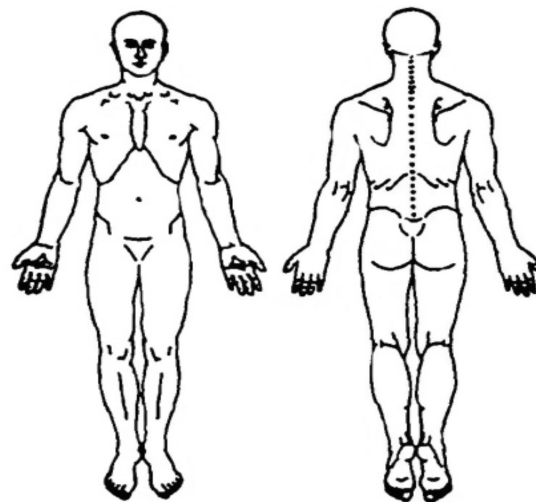
Area of injury/symptoms____Date your symptoms/injury started______________________

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_______Have you had an MRI? Yes ________ No _______

Please list any other tests you have received: ____

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, distances Transportation: 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: ____________	YES

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: ______________________