638 Sunset Park Dr. Ste 101
Sedro Woolley, WA 98284
Phone: (360) 856-4200
Fax: (360) 85604229
Website: www.swpt1.com

TODAY'S DATE______________

Last Name_________________________________ First Name_________________________________ M.I.__________

Street Address ____ City______________ State_____ Zip ___________

Home Phone (   )__________________ Cell Phone (   )___________________ Work Phone (   ) _______________

Emergency Contact: Name/Relation__________________________________ Phone Number(   )________________

Social Security Number________ - ____ - __________ Date of Birth ________/_________/__________

Sex: ☐Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Referring Physician__________________________________ Primary Care Physician______________________________
Surgeon (if applicable)_______________________________ Date of Surgery_____________________________________

Are you here because of a work-related injury? ☐ Yes ☐ No Claim #_________________Claim is ☐open ☐closed
Are you here because of an auto accident? ☐ Yes ☐ No Auto Claim #___________________________________
Do you have an attorney? ☐ Yes ☐ No Attorney's Name ___________________Attorney's Phone#______________
Date of Injury_________________________
What is your occupation?___________________________ Employer ____

Work Status: ☐ Fulltime ☐Part-time ☐ Unemployed ☐ Retired
☐ Regular duty ☐ Light-duty ☐ On time-loss ☐ Student

Have you had any diagnostic tests? ☐ Yes ☐ No If yes, when and where?__________________________________

Please circle all that apply: X-Ray CT Scan MRI Nerve Conduction Other________________________

Insurance Company_________________________________ Subscriber_____________________________________

For Medicare, DSHS and Labor and Industries Patients

Have you received any Physical, Occupational or Speech Therapy services since January 1, 2012? ☐ Yes ☐ No

If yes, how many visits occurred and where were the services received? _________________________________

Please provide the receptionist with your insurance card and photo ID so that we may copy it for billing accuracy

SEDRO-WOOLLEY
Physical Therapy

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Patient Name: ____ Date:_____________________

Reason for physical therapy: ____

Date pain or problem began: (be as specific as possible) _______________ Is this visit because of an injury? ☐Yes ☐ NO

Describe briefly how you were injured ____

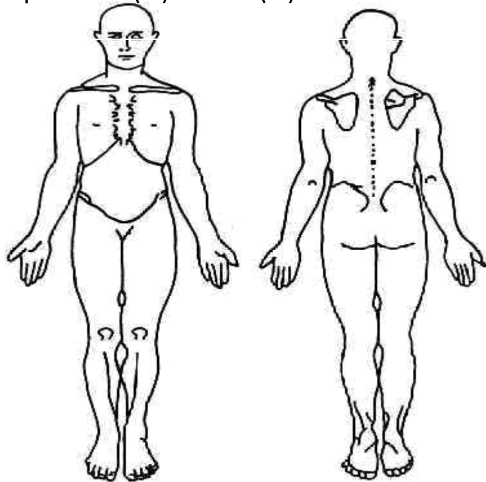
	Difficult	Unable		Difficult	Unable
Sit	( )	( )	House Work	( )	( )
Stand	( )	( )	Yard Work	( )	( )
Walk	( )	( )	Push/Pull	( )	( )
Lift	( )	( )	Drive in Car	( )	( )
Bend	( )	( )	Hobbies	( )	( )
Squat	( )	( )	Kneel	( )	( )

Current Pain Level while at Rest:
None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Current Pain Level with Activity:
None 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Is your pain:

- ☐ Constant
- ☐ At Night
- ☐ Intermittent
- ☐ Only with Activity



Indicate location of pain and what ty
present time. Use the symbols below to describe your pain. Only
indicate areas of pain related to your present injury or condition.

///: Stabbing

XXX: Burning

OOO: Pins & Needles

= = =: Numbness

+++: Achy

Medical Conditions
List all medications that you are taking: (you may provide a list for us to copy if you choose)________________________
____
List any allergies you may have: ____
Prior Surgeries: ____

Please check any medical conditions you currently have or have had in the past:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	**Diabetes**	☐	☐	**High Blood Pressure**	☐	☐	**Heart Disease**	☐	☐	**Arthritis**
☐	☐	**Cancer**	☐	☐	**Chest Pain**	☐	☐	**Irregular Heart Beat**	☐	☐	**Asthma**
☐	☐	**Stroke**	☐	☐	**Dizziness**	☐	☐	**Shortness of Breath**	☐	☐	**HIV/Aids**
☐	☐	**Hepatitis**	☐	☐	**Hepatitis C**	☐	☐	**Tuberculosis**			

Are you pregnant? **Yes** **No** **N/A**
Do you have a pacemaker? **Yes** **No**

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CONSENT AND RELEASE FORM

CANCELLATIONS & NO-SHOWS

Cancellations or changes must be made by the day prior to the scheduled appointment. If a patient fails to show for three scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and no further appointments will be scheduled until we are notified by the physician.

TIMELINESS

We make every effort to start your appointment at their scheduled time. Occasionally we are delayed by an unexpected event with another patient. If you arrive more than 10 minutes late for your appointment you may be asked to reschedule. The therapist can choose to proceed with the treatment, but your treatment will end at its scheduled time so that other patients will not have to wait.

FINANCIAL POLICIES

We will gladly bill most insurance companies. We will do our best to verify that we can bill your insurance company. We will also make every attempt to obtain accurate information regarding your physical therapy benefits. If payment is denied by your insurance company after you have received treatment, you are responsible for the balance on your account. If we find that your insurance company does not cover physical therapy treatment, we will do our best to work out a solution for you so that you may receive the treatment needed.

Many insurance plans will require a co-payment. Patients are responsible for making their co-pays at the time of their visit.

Payment must be made either at the time services are rendered or upon the receipt of your bill in the mail unless you contact us to make other arrangements. We are very willing to work out a payment schedule with you if your financial situation will not let you pay the full balance. If you do not contact us and your account is excessively past due, it will be turned over to collections.

If you have any questions about financial policies or your bill, please call (360) 856-4200.

Please advise us immediately of any changes that may affect your billing (change in insurance policy or claim number, address etc…)

PATIENT CONSENT AND RELEASE

- I understand that Sedro Woolley Physical Therapy is not responsible for any personal belongings that I bring to the clinic
- I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement or pending claims. I understand that the parent/guardian of a minor will be responsible for payment.
- I authorize Sedro Woolley Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Sedro Woolley Physical Therapy for any benefits available under my insurance plan. This information includes any photos taken during treatment.
- I acknowledge that I have read and understand the cancellation, no-show and financial policies as stated above.
- I hereby consent to treatment by Sedro Woolley Physical Therapy.

Patient Signature____ Date______________ ___

(Parent or guardian's signature if patient is under the age of 18)

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NOTICE OF PRIVACY PRACTICES

Effective Date: Jan 1, 2008

Sedro Woolley Physical Therapy
638 Sunset Park Dr Ste. 101
Sedro Woolley, WA 98284

THIS NOTE 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 the clinic at (360) 856 4200.

WHO WILL FOLLOW THIS NOTICE

This notice describes Sedro *Woolley Physical Therapy* and that of:
1) Any health care professional authorized to enter information into your chart. 2) All departments of the practice.
3) Any member of a volunteer group at our practice. 4) All employees, staff and other practice personnel.

All these entities follow the terms of this notice. In addition, these entities may share health information with each other for treatment, payment, of health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

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 of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Washington State Law governs a patient's right of access to their healthcare information maintained by a healthcare provider. We are required by law to:
1) Make sure that your medical information is kept private. 2) Give a notice of our legal duties and privacy practices with respect to your medical information. 3) Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION AS FOLLOWS:

All of the ways we are permitted to use and disclose information will fall within one of the following 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 staff 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 Health Care Operations: We may use and disclose medical 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 of our patients receive quality care. 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.
To 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.
For 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 information about you when required to do so by federal, state, or local law.
To Avert a Serious Threat to Health or Safety: Any disclosure of your health information would only be to someone who was able to help prevent a threat against the health or safety of any individual.

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
To Comply with Worker's Compensation Laws: If you make a worker's compensation claim, we may release information about you to anyone who is working with your claim.
For Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:
1) To prevent or control disease, injury or disability. 2) To report births or deaths. 3) To report child abuse or neglect. 4) To report reactions to medications or problems with products. 5) To notify people of recalls of products they may be using. 6) To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease. 7) To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make the disclosure if you agree or when required or authorized by law.
For Health Oversight Activities as Authorized by Law: These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your medical information 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 to obtain an order protecting the information requested.
For Law Enforcement: We may release your information for purposes such as when we receive a subpoena, court order, or other legal processes. We may also release your information if you are a victim of a crime or have been involved in a crime.
To Coroners, Medical Examiners, and Funeral Directors: We may release your medical information consistent with applicable laws allowing these people to carry out their duties.
To Authorized Federal Officials for National Security and Intelligence Activities: We may release your medical information about you for intelligence, counterintelligence, and other national security activities authorized by law.
To Authorized Federal Officials for Protective Services for the President and Others: We can disclose your information to authorized federal officials so they may provide protection to the President or any other authorized individuals.
To Correctional Institutions if you are in Jail or Prison: We may release your medical information as necessary for your health and the health and safety or others.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:
Right to Inspect and Copy: You have the right to inspect and copy information that may be used to make decisions about your care. Usually, this includes medical and billing records.
You must submit your request in writing to Sedro Woolley Physical Therapy. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. The cost of copying will be given to you upon your request of copies. You will receive your copy within 15 days of receipt of your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice.
Your request must be made to us in writing. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it in not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
1) Was not created by us, unless the party that created the information is no longer available to make the amendment. 2) Is not part of the medical information kept by this practice. 3) Is not part of the information, which you would be permitted to inspect and copy. 4) Is accurate and complete.
Any amendment made to your information will be disclosed to those with whom we disclose information as previously specified.
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.

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You must submit your request in writing to Sedro Woolley Physical Therapy. Your request must state a time period, which may not be longer than seven years and may not include dates before Jan 1st, 2008. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions: You have the right to restrict certain uses and discloses of your health and billing records.

You must deliver this request in writing to us.

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. However, we are not required to agree with your request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

You must make your request to us in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Paper Copy of this Notice: You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, contact Sedro Woolley Physical Therapy at (360) 856-4200.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

COMPLAINTS

If you believe your privacy rights have been violated, 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 the accounts manager at (360) 299-2781. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical 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 you 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.

I acknowledge receipt of a copy of the Sedro Woolley Physical Therapy “Notice of Privacy Practices.”

____ _______________

Patient or Personal Representative Signature Date