Olympia Physical Therapy & Industrial Rehabilitation, INC.

DBA: Hawks Prairie Physical Therapy & Northwest Sports Medicine Center

(Please Print)

DID YOU FIND US THROUGH A YELLOW PAGES AD? If so, please indicate which directory:	❑ Yellowbook	❑ Other Book _____

Did you choose us for Another Reason? Please Specify:	❑ Friend or Family	❑ Attorney	❑ Doctor	❑ Location	❑ Online Search	❑ Other	NAME:

EMAIL ADDRESS:_____@_____

DATE OF INJURY_____/_____/_____ Cause of injury: ❑ Motor Vehicle ❑ On-the-job ❑ Other _____

PATIENT INFORMATION

Patient's Last Name First MI	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Home Phone ( )	Mobile Phone ( )	Social Security Number	Date of Birth	Age	Sex ❑ M ❑ F

Street Address	City	State	Zip

P.O. Box	City	State	Zip

Employer Name and Address	Employer Phone Number ( )

RESPONSIBLE PARTY (if different than patient)

Last Name First	Date of Birth	Address (if different)	Home Phone Number ( )

Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name and Address	Phone Number ( )

Subscriber's Name	Subscriber's SSN	Date of Birth	Group Claim #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name Of Secondary Insurance (if applicable)	Subscriber's Name	Date of Birth	Group #	Policy #

Patients Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other_____

IN CASE OF EMERGENCY

Name of Friend/Relative (not living at same address)	Relationship to Patient	Home Phone # ( )	Work Phone # ( )

BY SIGNING THE REVERSE SIDE OF THIS FORM, THE (patient,parent/guardian) AGREE THAT:

I authorize physical therapy treatment and procedures provided by an authorized employee of Olympia Physical Therapy (OPT), Hawk's Prairie Physical Therapy (HPPT) or Northwest Sport's Medicine Center (NWSMC) as directed by my physician's prescription and authorize all insurance benefits to be paid directly to OPT, HPPT or NWSMC.

I understand I am responsible to know my insurance coverage and assume all financial responsibility for the balance of any charges not covered by insurance.

I agree that all co-payments are due at the time of service. If I fail to pay co-payments at the time of service there will be a one time billing statement that will include a $10 non-negotiable service charge, after which any unpaid balance will be turned over to a professional collection agency. All returned checks will be assessed a $40 fee, per return, which will also be turned over to a professional collection agency, should they remain unpaid within ten days of my being notified of the dishonored instrument.

Furthermore, **I understand that all accounts not paid in full at the time of service are due and payable within 30 days.** Accounts remaining in a delinquent status beyond 30 days are subject to a minimum finance charge of the greater amount of $5.00 or 1% per month (12% per annum), and probable assignment to Dynamic Collectors, Inc.

I agree that any dispute over my account will be governed by Washington State law, that the agreed venue for disputes will be Thurston County, and I agree to pay all collection costs and reasonable attorney fees associated with any dispute that may arise from my failure to pay my account in full. *Accounts assigned to a professional agency will incur an additional $25 collection fee charged to my account.*

I assign OPT and all affiliates the authority to release any information necessary for the purpose of processing medical claims and collecting unpaid balances on my account, and release OPT, HPPT or NWSMC from disclosure of the patient's record as provided by this paragraph.

RELEASE OF LIABILITY

IN CONSIDERATION of my being involved in a physical therapy program which permits use of the facility and equipment of Olympia Physical Therapy & Industrial Rehabilitation, Inc. (OPTIR), located at 2755 Mottman Road SW, Tumwater, Washington, and/or Hawks Prairie Physical Therapy (HPPT) and Northwest Sports Medicine Center (NWSMC), located at 8750 Tallon Lane NE, Lacey, Washington. The undersigned hereby fully understands and agrees to the following conditions prior to participating in physical therapy treatment:

I agree to indemnify, defend, hold harmless and release OPTIR, its elected and appointed officers, agents, employees, and volunteers from any and all lawsuits, damages, claims, judgments, losses, liability or expenses arising out of (1) the death of, personal injury, or property damage to myself, or my minor child, which may be sustained while using property or equipment owned by or under the control of OPTIR, or (2) any death or injury which results or increases by any action taken to medically treat me, or my minor child. All of the terms above shall apply whether or not caused by the alleged negligence, whether active or passive, or any acts or omissions of OPTIR, or any of its elected or appointed officers, agents, employees or volunteers.

I also understand that there are risks associated with participation in a physical therapy program, and I assume the risk of any injuries that I, or my minor child, may sustain during any of the activities that may be engaged in during the course of treatment.

I know there is the risk of injury or death involved in my participation in a physical therapy program at OPTIR and/or it's affiliates;

I voluntarily participate in a physical therapy program at OPTIR and/or it's affiliates, and I sign my name below so that I may participate - I can choose not to sign this agreement by choosing not to participate;

I agree that if anything happens to me or my minor child while participating, including injury or death, I release OPTIR, it's affiliates and any of its employees from liability; and;

If I am injured (or my minor child) while participating, I agree that anyone who provides medical assistance shall not be liable if they cause my (or my minor child's) death, increase my (or my minor child's) injury or cause additional injury.

I have read, understand and approve this RELEASE FROM LIABILITY. IF the participant is a minor, the undersigned parent or legal guardian warrants and represents that this RELEASE, its significance and the assumption of risk has been explained to and understood by my minor child or ward; and hereby declare, under penalty of perjury, that I am the parent or legal guardian of the named participant.

PATIENT SIGNATURE	DATE
PATIENT/GUARDIAN SIGNATURE	DATE
PARENT NAME (PRINTED)	PATIENT NAME (PRINTED)

OLYMPIA
PHYSICAL THERAPY
& Industrial Rehabilitation, Inc.

HEALTH INFORMATION QUESTIONNAIRE

Name: _____ Date: _____

What area are we treating? _____ Height: _____ Weight: _____lbs

If you were injured, how did the injury occur? _____

_____ Date of injury/surgery: _____

Yes	CONDITION	WHEN	Yes	CONDITION	WHEN	Yes	CONDITION	WHEN
	Arthritis			Heart Disease			Polio	
	Asthma			Hepatitis			Rheumatic Fever	
	Bladder Infection(s)			High Blood Pressure			Seizure Disorder	
	Bronchitis			Immune Deficiency Illness			Spinal Cord Injury	
	Cancer			Kidney Disease			Sprain/Strain	
	Cerebral Palsy			Low Back Injury			Stroke	
	Congenital Anomalies			Multiple Sclerosis			Surgery	
	Diabetes			Muscular Dystrophy			Ulcers	
	Gastrointestinal Problems			Neck Injury			Fibromyalgia	
	Head Injury			Pneumonia			Other:	

PLEASE EXPLAIN ANY YES ANSWERS (e.g. TYPE OF SURGERY, MULTIPLE EPISODES, ETC.)

_____

_____

List all medications you are currently taking: _____

_____

In an effort to tailor your treatments to your individual needs, please answer the following questions (circle answer):

Do you have concerns about exercising in a group environment?	**YES**	**NO**	**OTHER:**
How do you learn best?	❑ **Listening**	❑ **Reading**	❑ **Doing**

Do you have any special personal concerns that need to be addressed during your treatment with us?

YES	**NO**	If yes, please explain:

Using the pain scales located below, please answer the following 3 questions on a scale of 0 to 10.

Place the number corresponding to your pain level on the line next to each of the three questions.
Zero being the least amount of pain and 10 being the most severe.
You may use either or both pain scales below to help with your decision.

_____ Worst intensity during the past 30-day period

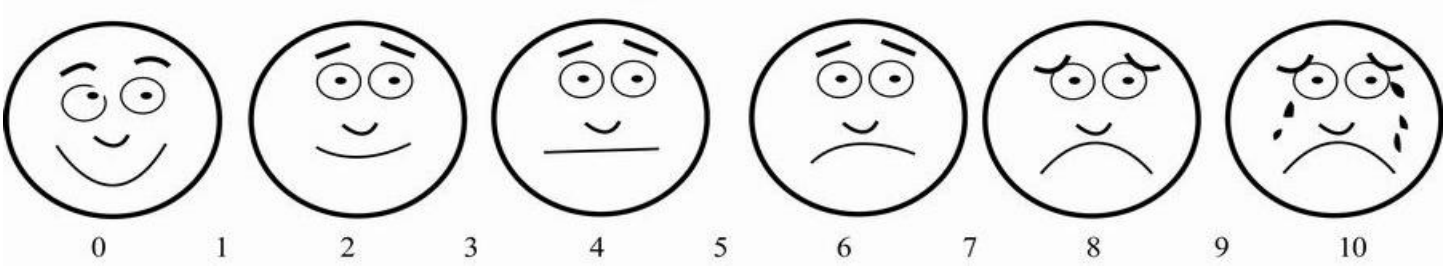
_____ Least intensity during the last 30-day period

_____ You pain level right now

Number		Functional Descriptor
10	Immediate Emergency Hospitalization	Worst pain imaginable requiring immediate emergency Hospitalization
9		Pain that causes disability between levels 7 and 10. Nearing need for hospitalization.
8		Pain that causes disability between levels 7 and 10. Nearing need for hospitalization.
7	Severe disabling pain	Severely disabling pain. You cannot move or use the painful area. You have difficulty speaking/engaging in conversation. You have difficulty concentrating on anything but pain. Needing to lie down, and the pain related tearfulness are also common at this level.
6		Pain that causes disability between levels 5 and 7.
5	Very disabling pain	Very disabling pain. Causes great difficulty moving or applying any strength through the painful area. You would stop using the painful area for the present activity.
4		Pain that causes disability between levels 3 and 5.
3		Pain is starting to visibly disable you. It is starting to cause difficulty moving or applying strength through the painful area, affecting your productivity or performance. Causes you to take small breaks to rest or stretch.
2		Non-disabling pain or discomfort. Does not impair ability to move fully, with normal speed or strength.
1		Non-disabling pain or discomfort. Does not impair ability to move fully, with normal speed or strength.
0.5	Non-disabling pain	Non-disabling pain or discomfort. Does not impair ability to move fully, with normal speed or strength.
0	No pain	No pain or discomfort.

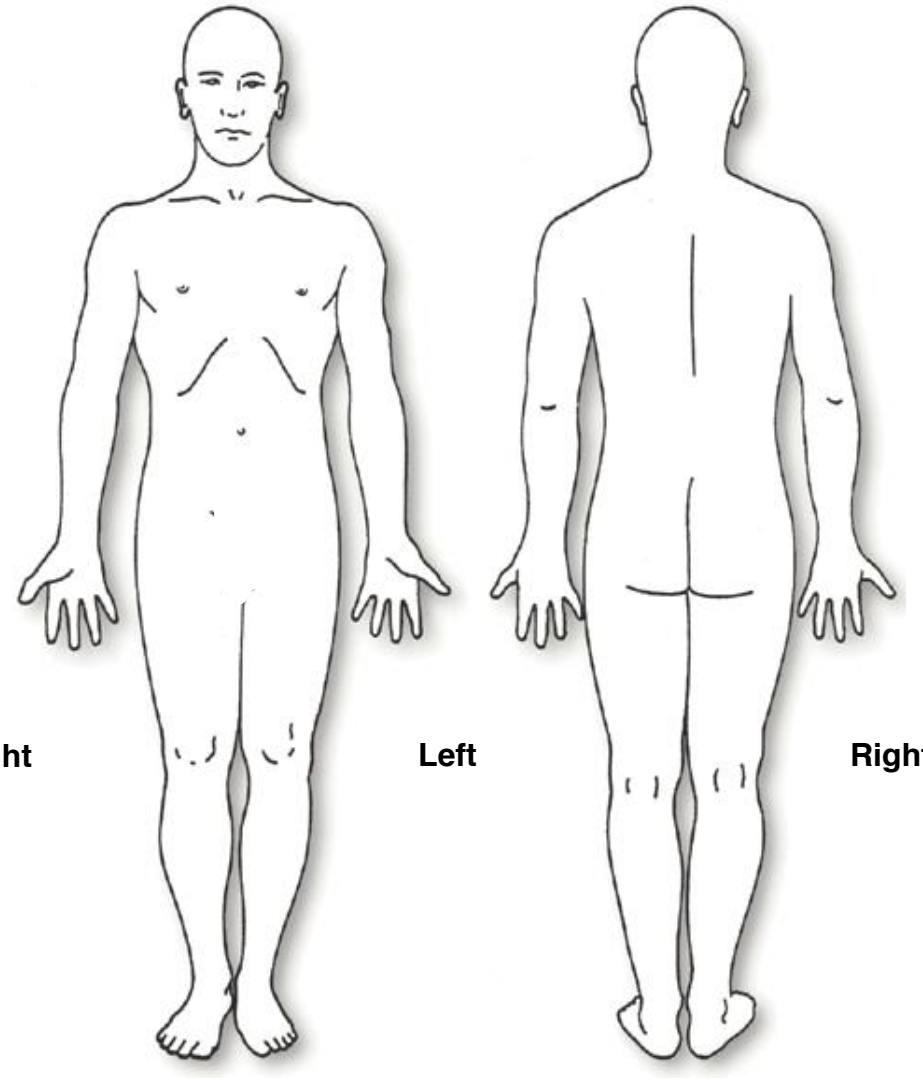
UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs.
The 0-10 scale is for patient self-assessment. Please use the faces to help explain and express your pain level.



Where is your pain?

Please use the key below to indicate on the drawing the nature and areas of your pain.



Right **Left** **Right**

KEY

Numbness	
Severe Pain	
Moderate Pain	
Shooting Pain	
Pins and Needles	

PRIVACY PRACTICES

For

OLYMPIA PHYSICAL THERAPY AND INDUSTRIAL REHABILITATION, INC., HAWKS PRAIRIE PHYSICAL THERAPY AND NORTHWSET SPORTS MEDICINE CENTER, hereby referred to as ***OPT AND AFFILIATES***

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

EFFECTIVE: April 1, 2003

WE HAVE A LEGAL RESPONSIBILITY TO PROTECT YOUR HEALTH INFORMATION

We are required to protect the privacy of health information about you and that can be identified with you. Every time you visit one of our clinics for treatment, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This notice describes the types of uses and disclosures of your health information and gives you specific examples of the various disclosures.

YOUR HEALTH INFORMATION RIGHTS

Although your medical records are the physical property of OPT AND AFFILIATES, the information belongs to you. You have the right to:

Obtain a copy of this notice upon request. We will provide a copy of this notice not later than your first date of service with us.

Inspect and copy your health record. Your request must be in writing. We may charge related fees. Currently WAC 246-08-400 allows providers to charge a $23.00 clerical fee, plus $ 1.02 per page for each of the first 30 pages, plus $ .78 for each additional page beyond the first 30, and 8.7% sales tax (as required by law). If mailing is required, postage may also be billed. Furthermore, we have the right to hold the records until payment in full has been received in our office. Rather than providing you with a full copy of the record, we may give you a summary or explanation of the health information about you, if you agree in advance to the format and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, explaining why we will not grant your request, and describing your right to request a review of our denial.

Obtain an accounting of certain disclosures that are made of your health information. You can request an accounting of disclosures by submitting a request in writing to our Compliance Officer. Limited use and disclosure without authorization is permitted in circumstances where there is a prevailing public interest, including: disclosure to report abuse and neglect, for governmental functions and public health activities, medical research and for billing, judicial and/or law enforcement purposes.

Amend your health record. You have a right to request that we make amendments to your medical records. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 2 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received health information about you and who need the amendment.

Request a restriction on certain uses and disclosures of your information. We are not required to agree to requested restrictions. Even if we agree to a request, in certain situations, your restrictions may not be followed. Limited use and disclosure without authorization is permitted in circumstances where there is a prevailing public interest, including: disclosure to report abuse and neglect, for governmental functions and public health activities, medical research and for billing, judicial and/or law enforcement purposes.

Request communication of your health information by alternative means or at alternative locations. You have the right to request how and where we contact you about protected health information. For example, you may request that we contact you at your work address or phone number, or by email. Your request must be in writing. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact.

Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OPT AND AFFILIATES' DUTIES

Our organization is required to:

- Protect and maintain the privacy of your health information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information at alternative locations or by alternative means.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described below, in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

1. **For treatment.** Information obtained by a physical therapist or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your referring physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from the clinic.
2. **For payment.** A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used OR If your bill becomes delinquent and remains unpaid, your account could be turned over to a professional collection agency. In the event that this becomes necessary, we will disclose information to the collection agency in order to enable them to collect any outstanding balances owed to OPT AND AFFILIATES.
3. **For regular healthcare operations.** Members of our business services staff may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

SPECIAL DISCLOSURES

1. **Appointment Reminders:** We may contact you to provide you with appointment reminders.
2. **Communication with Family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You can object to such use and disclosure in writing to the Compliance Officer.
3. **Information about our Services:** We may contact you with information about treatment, services, products, or health care providers that may be of interest to you. We may give you gifts of a nominal value, such as OPT AND AFFILIATES pens and T-shirts.
4. **Government Oversight and Related Agencies:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs established by law; to attorneys, insurance companies, collection agencies, or other similar parties, as necessary to obtain payment for our services, or to defend against or assist in certain legal actions; to public health or legal authorities charged with preventing or controlling disease, injury or disability; in response to a valid subpoena or for law enforcement purposes, as required by law; to the FDA, health information relative to adverse events with respect to food, supplements, product or product defects or post marketing surveillance information to enable product recalls, repairs or replacement; to the military, as required by military command authorities, for members of the armed forces.; and, should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.
5. **Research:** We may disclose information to researchers when their research has been approved after ownership and management of OPT AND AFFILIATES have reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and your physical condition. You can object to such use and disclosure in writing to the Compliance Officer.

ANY OTHER USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION ABOUT YOU REQUIRES WRITTEN AUTHORIZATION

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose personal health information about you. If you sign a written authorization allowing us to disclose personal health information about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose personal health information about you after we receive your cancellation, except for disclosures that were being processed before we received your cancellation.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, or if you believe your privacy rights have been violated by the unauthorized and/or improper use and disclosure of your health information and would like to file a complaint with us, you may contact:

Stacey Huntington, Compliance Officer
2755 Mottman RD SW
Tumwater, Washington 98512
(360)352-5077

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services.

All complaints will be investigated and appropriate corrective actions taken to ensure that OPT AND AFFILIATES are in compliance with privacy regulations. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

Acknowledgment of Receipt of Privacy Practices

I, _____, agree that Olympia Physical Therapy & Industrial Rehabilitation Inc., Hawks Prairie Physical Therapy and Northwest Sports Medicine Center (hereby referred to as **OPT AND AFFILIATES**) will use or disclose my health information for billing, treatment and healthcare operations. I have received a copy of **OPT AND AFFILIATES'** privacy practices. I have been informed of my right to request restrictions on use and disclosure of my health information.

By signing below, I acknowledge that I have received a copy of **OPT AND AFFILIATES'** privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

In lieu of patient signature, I, _____, a staff member of **OPT AND AFFILIATES'**, state that _____ was provided with a current copy of our privacy practices.

OR

Acknowledgment of receipt of the **OPT AND AFFILIATES'** Privacy Practices was not received because

_____

_____

Employee Signature _____ **Date** _____

Federal privacy laws limit our access to your health insurance information, including specific limits on physical therapy coverage. While we do our best to keep you informed of your health insurance company's limitations on physical therapy, it is important that you contact your health insurance carrier for a complete declaration of benefits to avoid unexpected healthcare expenses you will be responsible for.