STRIDE PHYSIO, PLLC — Patient Registration

Name _____ Date _____
Last *First* *MI*

Address _____
Street *City* *State* *Zip*

Birth Date _____ Age _____ Gender _____

Phone #s: Home _____ Work _____ Cell _____

E-mail _____ Contact Preference: ☐Home ☐Work ☐Cell ☐E-mail

Employer/Occupation _____ Marital Status: ☐Single ☐Married ☐Other

Referring Provider _____ Phone _____

Address of Referring Provider _____

Emergency Contact _____ Phone _____

INSURANCE INFORMATION – *Please provide insurance card for copying at 1st appointment*

Primary Insurance _____ Customer Service Phone _____

Subscribers Name _____ Birth Date _____

ID Number _____ Group Number _____

Patient's relationship to insured: ☐ self ☐ spouse ☐ child ☐ other Co-Pay amount _____

Secondary Insurance _____ Customer Service Phone _____

Subscribers Name _____ Birth Date _____

ID Number _____ Group Number _____

Patient's relationship to insured: ☐ self ☐ spouse ☐ child ☐ other

IF YOU HAD AN ACCIDENT, PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other _____

Insurance Company _____ Claim Number _____

Address _____ Claims Adjuster _____ Phone _____

Attorney _____ Phone _____

Please read the following statements and sign below if you agree to the terms:

1. I authorize the release of any and all medical information that is necessary to process my claims or assist in my health care.
2. I have received a copy of the Notice of Privacy Practices and understand my rights to privacy and confidentiality regarding access to my medical records.
3. I authorize the payment of medical benefits for all claims filed to my insurance company. I am financially responsible for any balance.

Signed _____ Date _____

stride
PHYSIO

Current Health Condition

Name:_____ Todays Date:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Hand Dominance ☐Right ☐Left Referring Provider:_____

Occupation:_____ Employer:_____

Diagnosis or reason for seeking physical therapy:_____

Date of onset (or approximately how long have you experienced symptoms):_____

Location of symptoms:_____

Have you had testing or imaging? ☐Yes ☐No If yes, what was done?_____

Have you had this problem before? ☐Yes ☐No If so when?_____

Have you had a history of trauma? ☐Yes ☐No If yes, explain:_____

Was a surgery performed? If so when? _____

Have you had physical therapy or other treatments prior to current health condition? ☐Yes ☐No

If you have pain, rate your pain level on a scale of 0-10 (0=no pain, 10=most extreme pain)

Current pain level_____ At worst_____ At best_____

How would you describe your pain: ☐Ache ☐Dull ☐Sharp ☐Burning ☐Shooting
☐Deep ☐Superficial ☐Numbness ☐Tingling
☐Other:_____

Are your symptoms: ☐Constant ☐Intermittent ☐Infrequent ☐Variable

Is your pain worse at a certain time of day? ☐Yes ☐No
If yes, ☐Worse at night ☐Worse in morning ☐Other?_____

Do you have difficulties getting to sleep due to pain? ☐Yes ☐No

Do you wake due to pain? ☐Yes ☐No If yes, # of times per night:_____

Client Name:_____

What household duties are you having difficulties performing?

☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Yard Work

☐ Grocery Shopping ☐ Other:_____

What activities are difficult to perform due to your condition?

☐ Sitting ☐ Standing ☐ Squatting ☐ Walking ☐ Lifting

☐ Reaching ☐ Dressing/Grooming ☐ Driving ☐ Stairs

☐ Gripping/pinching ☐ Kneeling ☐ Lying down ☐ Work Tasks

☐ Changing positions ☐ Laughing, Coughing, Sneezing ☐ Sexual Activity

☐ Other:_____

What activities make your pain/symptoms better?_____

What activities make your pain/symptoms worse?_____

How has lifestyle/quality of life been impacted by this problem?_____

_____

How would you rate your current level of stress? ☐ Low ☐ Medium ☐ High

How do you manage stress?_____

Previous Surgeries (*please list all and date*)

1._____

2._____

3._____

4._____

Previous Injuries/Orthopedic Problems/Motor Vehicle Collisions (*include date*)

1._____

2._____

3._____

4._____

Current Medications and/or Supplements and reason for taking

1._____

2._____

3._____

4._____

What hobbies, sports, fitness &/or recreational activities do you do regularly? _____

_____

What goals do you have for therapy? _____

_____ _____

Signature *Date*

Client Name:_____

General Medical/Health History

How would you classify your general health: ☐Good ☐Fair ☐Poor

In terms of your general health, please check ALL that apply:

☐Alcohol/Drug Problems
☐Allergies
☐Anemia
☐Asthma/Breathing Difficulties
☐Cancer
Type:_____
☐Change in Bowel/Bladder Function
☐Chest Pain/Angina
☐Concussions
☐Depression
☐Diabetes I or II
☐Fibromyalgia
☐Heart Attack
☐Heart Disease
☐Heart Palpitations
☐Hepatitis
☐Hernia
☐High/Low Blood Pressure
☐HIV
☐Hypoglycemia
☐Intolerance to cold/heat
☐Jaw/Dental Issues
Explain:_____
☐Kidney Problems
☐Liver/Gallbladder problem
☐Metal Implants
☐Multiple sclerosis
☐Night pain
☐Numbness/Tingling
☐Osteoarthritis
☐Osteoporosis
☐Pacemaker
☐Pain with Cough/Sneeze
☐Physical Abnormalities
☐Polio
☐Recent Dizziness/Fainting
☐Recent Headaches
☐Recent Fever
☐Recent Fractures
☐Recent Nausea/vomiting
☐Recent Unexplained Fatigue
☐Recent Vision Changes
☐Rheumatoid Arthritis
☐Ringing in the ears
☐Seizures/Epilepsy
☐Skin Abnormalities
☐Smoking History
☐Stroke/TIA
☐Surgeries
☐Unexplained Weight Loss/Gain
☐Vertigo/Vestibular Disorders
☐Vision Changes
☐Other
_____

Pelvic Medical/Health History

In terms of your pelvic health, please check ALL that apply (complete only if applicable for care):

☐Coccyx Pain
☐Constipation
☐Currently Pregnant
☐Diarrhea
☐Endometriosis
☐Erectile Dysfunction
☐Fecal or Gas Incontinence
☐IBS
☐Painful Ejaculation
☐Painful Periods
☐Pelvic Pain
☐Physical or Sexual Abuse
☐Prostate Disorders
☐Sexual Dysfunction
☐Sexually Transmitted Disease
☐Shy Bladder
☐Urine Leakage
☐Vaginal Dryness

Menopause? ☐Yes ☐No If yes, date:_____

Date of Last Pelvic Exam:_____

Number of Pregnancies:_____

Number of Child Births:_____

Number of C-Sections:_____

Number of Vaginal Deliveries:_____

_____ _____

Signature *Date*

STRIDE PHYSIO, PLLC

Financial Policy

Thank you for choosing Stride Physio. We are fully committed to providing you with the highest quality physical therapy and want to foster a life-long patient/provider relationship regardless of your insurance coverage. Please read this policy carefully and sign and date at the bottom.

Patient Responsibilities

You can help ensure an efficient and informed experience by assisting with the following:

- Provide us with your most current insurance card and picture ID.
- Be empowered by knowing your insurance benefits and limitations. This can be attained by filling out the attached "Insurance Benefits Worksheet", which will guide you in your conversation with your insurance company. You can also refer to your insurance plan summary/plan document for assistance. ***Our staff will routinely obtain a quote of your benefits but please keep in mind, that we cannot guarantee the quotes we receive from your insurance carrier.***
- If required by your insurance, provide us with a referral from your primary care or referring provider.
- If available, bring in copies of any pertinent medical records, and/or imaging (MRI/CT/arthrogram/X-ray).
- Be prepared to provide co-payments at time of service.
- Complete required incident/accident forms within 30 days of date of service.
- Inform us of any changes with your personal information and insurance benefit.
- **Please provide us at least 48 hours notification, should you need to cancel or reschedule an appointment. As we are a small practice, cancellations have a big impact on our business.**

Insured Clients

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot legally change or negotiate these amounts.

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our billing specialist and make payment arrangements. **Co-pays are due on the date of service. We take cash, check or credit cards.**

Deductibles, co-insurance and amounts that are not covered by your insurance will be billed to you and payable within 30 days of receipt. If you have a limited or high deductible plan and would like to pay at the time of service, we are happy to provide an estimate your costs to be paid at the time of service.

Non-participating insurance – if we do not participate in the insurance you have, we will file a claim as a courtesy, except Medicaid which we are unable to bill. To help offset the costs of choosing our care, despite the fact that we are out of network with your insurance carrier, we can also offer you a 10% discount if you pay at the time of service. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Motor Vehicle Accident (MVA) and Third Party Clients

We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer

payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request, provided we are furnished the necessary information at the date of service.

Un-insured or Under-insured Clients

We offer a 20% discounted rate for full payment at the time of service.

We bill in timed units for the various procedures we provide. Each unit is approximately 15 minutes (+/– a few minutes). On average each unit is $50.00. So if paying out of pocket at the time of service for 4 units the amount will be $160.00. **Initial evaluations are $200.00 and standard appointments are $160.00**. Payment plans are available upon request.

Payments

Payment options – we accept checks, cash, money orders and major credit cards for payments (no post-dated or 3rd party checks).

Alternative payment arrangements – if you are unable to pay your balance when due, arrangements can be made with our office for a payment plan. To contact our biller you can email billing@strideseattle.com.

Other Charges

Late Cancellation/No show – We request that you provide at least 2 business days advance notice if you need to cancel or reschedule an appointment. Any appointment cancelled **less than one business day** in advance will result in a **$75.00** fee charged directly to you, the patient. Missed appointments will be charged a fee of **$100.00**. *After three cancellations per plan of care, appointments will only be made on a weekly basis.*

Delinquent accounts – we charge a $10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Clients assigned to collections may be denied additional service.

Returned check fee – $30.00 will be charged for any check returned by the bank for non-sufficient funds (NSF).

Classes – if you attend an exercise class or personal training session here, you will be charged directly at the time of the class. We are unable to bill insurance for these services.

Signature _____ *Date*_____

STRIDE PHYSIO, PLLC
HIPAA Notice of Privacy Practices for Personal Health Information

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.

Dear Stride Physio Patient:

This is your Health Information Privacy Notice from Stride Physio. Your are receiving this notices as mandated by law to inform you of the policies and procedures employed by this clinic and its staff in order to ensure the privacy of your Personal Health Information (PHI). This notice also describes your rights with respect to you PHI and how you can exercise those rights. PHI includes individually identifiable health information in any form, including information transmitted orally, or in written or electronic form.

We are required by law to:

1. Notify patients about their privacy rights and how their PHI can be used.
2. Adopt and implement privacy procedures.
3. Train employees so that they understand the privacy procedures.
4. Designate an individual responsible for ensuring that privacy practices are adopted and followed.
5. Secure patient records containing individually identifiable health information.

Permitted Uses and Disclosures

The HIPAA Privacy Rule generally requires that we make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. We may use/disclose your PHI *without* consent in the following cases:

1. **Treatment**: The provision, coordination or management of health care and related services among health care providers or by health care provider with a third party, consultations between health care providers regarding a patient, or the referral of a patient by one health care provider to another.
2. **Payment**: The various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their covered responsibilities, and to obtain or provide reimbursement for the provision of health care. This includes determining eligibility or coverage under a plan, adjudicating claims, billing and collection activities and justification of charges.
3. **Health Care Operations**: Administrative, financial, legal and quality improvement activities necessary to run our business including quality assessments, review of competence and qualifications of health care workers, accreditation, conducting or arranging for medical review, legal and auditing services and business management.

Your PHI may also be used/disclosed to inform you of health related products or services provided by Stride Physio, alternative treatments or therapies, or in any communications made during a face to face encounter with you.

Special Uses and Disclosures

Your PHI may be used/disclosed without your authorization in the following special circumstances;

- Law enforcement activities.
- Public health risks or activities.
- Reports to appropriate authorities concerning victims of abuse, neglect or domestic violence.
- Health oversight activities and government benefit programs.
- Judicial and administrative proceedings (court order, warrant, and court subpoena for relevant information.
- Emergency situations with serious threats to health or safety.

- Specialized government functions.
- Worker's compensation.
- Appointment reminders.
- Individuals involved (family/friends) in your care or payment for your care.
- Research, if conducted without using information that could reveal your identity.
- Military and Veterans, as required by military command authorities.

We may use/disclose your PHI for other purposes if you authorize the specific use/disclosure in writing. You may revoke this authorization at any time, but it must be in writing.

Your Rights Concerning Your PHI

- ❖ You have the right to **access and copy** your "designated record set" (any piece of information that reflects a decision a provider makes regarding the patient). You may request that your record set, or portions of it, be copied. This request must be made in writing and may be subject to a reasonable copying charge. We have 30 days (50 in certain circumstances) to deliver the requested material to you.
- ❖ You have the right to receive an **accounting of disclosures** of your PHI. This excludes disclosures made to carry out treatment, payment or health care operations. An account would include disclosures made during the 6 years prior to the date of the request, and the date, recipient's name(s), description of PHI disclosed, and statement of purpose for the disclosure for each disclosure.
- ❖ You have the right to **request amendments or corrections** of your PHI. You must submit this request (see contact information at end of this notice) in writing and provide the reason for this request. In some circumstances we may have the right to deny your request. We will explain the reason for any denials, and you may have the right to appeal the denial.
- ❖ You have the right to request additional **restrictions or special limitations** regarding how we use or disclose your PHI. We may deny this request, but if we agree to it then we will be legally obligated to carry out the agreement. This request must also be made in writing.
- ❖ You have the right to request **alternative means of communications** to increase confidentiality. You must specify how communication is to be carried out (written, phone, electronic, etc.) and any other limitations (specific address or phone number, etc.) in a written request. We will honor reasonable requests.
- ❖ You have a right to **receive a paper copy of this notice**. We will issue a copy of this to you at the start of your course of treatment, and request that you sign a form stating that you have received this form.

Changes to Privacy Practices

We have the right to make revisions to this notice and to our privacy practices at any time. Revisions will apply to all PHI that we currently have, and any PHI that we obtain or generate in the future. Revisions will be posted with this notice in our clinic and on our website.

Questions and Complaints

If you have any questions about this notice, or would like an additional copy, please contact us at the information listed below. If you feel that we have violated your privacy rights or disagree with a decision that has been made regarding your PHI, you may file a complaint with the Privacy Officers listed below, and/or with the Secretary of the U.S. Dept. of Health and Human Services. Please note that you will not be penalized for filing a complaint with us or DHHS.

Stride Physio
Attn: Privacy Officer, Susanne Michaud
100 NE Northlake Way, Suite 200B
Seattle, WA 98105
206-547-7445ph/206-913-2486 fax

STRIDE PHYSIO, PLLC

Patient Name:_____ Date of Birth:_____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, (*print name of patient or patient's personal representative*), acknowledge that I have received a copy of Stride Physio's Notices of Privacy Practices. This notice provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed this Notice.

_____ _____

Signature of Patient or Personal Representative *Date*

Consent to Leave Messages

To ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPPA), we ask that you let us know where and with whom we are permitted to leave information about your upcoming appointment, account information or any other information you may want us to convey via telephone or electronic messaging.

- May we leave information on your mobile or home phone voice mail? ☐**YES** / ☐**NO**
- May we leave a message with someone who answers the phone at your residence? ☐**YES** / ☐**NO**
- May we leave a message at your place of employment? ☐**YES** / ☐**NO**
- May we call you partner, spouse, or emergency contact person and leave information? ☐**YES** / ☐**NO**

_____ _____

Signature of Patient or Personal Representative *Date*