# Client Registration

**Name**_____ **Date**_____
*Last* *First* *MI*

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

**Birth Date**_____ **Preferred Pronouns**_____

**Home#**_____ **Cell#**_____ **Email**_____

**Contact Preference:** ❑Home ❑Cell ❑Email **How did you learn about Stride?**_____

**Referring Provider**_____

**Emergency Contact Name**_____ **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 _____

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.
4. I consent to receiving physical therapy services at Stride Physio.

**Signed**_____ **Date**_____

# Current Health Condition

**Name**_____**Date**_____

**Birth Date**_____ **Age**_____ **Height**_____ **Weight**_____

**Gender**_____ **Hand** **Dominance:** ❑ Right ❑ Left

**Occupation**_____

**Reason for seeking physical therapy**_____

**What are your symptoms?**_____

**Location of symptoms?**_____

**When did your symptoms begin?**_____

**Are your symptoms changing?**_____

**Are your symptoms:** ❑ Constant ❑ Intermittent ❑ Infrequent ❑ Variable

**Are your symptoms worse at a certain time of day?** ❑ Yes ❑ No

If yes, worse at ❑ Night ❑ Morning ❑Other_____

**Does this condition affect your sleep and if so how?** _____

**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 for this condition?** ❑ Yes ❑ No

If yes, please describe_____

**What activities make your pain/symptoms better?**_____

**What activities make your pain/symptoms worse?**_____

**How has quality of life been impacted?**_____

**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._____

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

1._____

2._____

3._____

**Current Medications and/or Supplements and reason for taking**

1._____

2._____

3._____

**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 Problems
☐ Metal Implants
☐ Multiple sclerosis
☐ Night pain
☐ Numbness/Tingling
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Pain with Cough/Sneeze
☐ Physical Abnormalities
☐ Polio
☐ Recent Dizziness
☐ 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**

☐ 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:**_____

# 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. ***Our staff will obtain a quote of your benefits at your first visit 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.**

**Health Insurance**

If Stride Physio is a participating provider (in-network) with your insurance carrier, we will bill your insurance directly and accept their payment plus any co-payments, co-insurance, and deductibles as payment in full.

*o Please note: co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot legally change or negotiate these amounts. • If your plan requires a co-pay with an office visit, you agree to pay this at the time of your visit. • If your insurance requires a pre-authorization, our office will make all efforts to obtain this. Should your insurance or its affiliates not authorize your visit(s), you agree to pay for these visits in full. • Deductibles, co-insurance and amounts that are not covered by your insurance, including those denied for reasons of non-medical necessity, will be billed to you and payable within 30 days of receipt. • If Stride Physio is not a participating provider for your insurance plan, also known as out-of-network, you may still have out-of-network benefits, in which case Stride will courtesy bill your insurance and any patient responsibility will be billed directly to you after insurance processes, due within 30 days. o If you do not have out-of-network benefits you can opt to do self-pay which is due at time of service and we do not bill your insurance at all.*

**Motor Vehicle Accidents (MVA) & 3rd Party Billing**

• Stride will bill your car insurance, personal injury protection (PIP).

• If your car insurance PIP does not pay within 30 days, the bill becomes your responsibility. • If your PIP coverage is exhausted, we will bill your private insurance at your request, provided we are furnished the necessary information at the date of service.

• Stride does not accept 3rd party claims, meaning we will not defer payment obligations while a case settles.

• Stride is unable to confer with attorneys or defer payment obligations while a case settles. • Workman's Compensation (L&I) Billing

• Stride bills Labor & Industry claims if you provide us with a claim number, name & number of claim representative and physician referral.

**Self-Pay**

• *Those paying cash for physical therapy services will receive a discounted rate if paid at time of service. See Billing & Fees Sheet for details on prices.*

o Please note: We are unable to retroactively apply self-pay discounted rates once we have billed your insurance.

• Most specialty services and classes are not covered by insurance because they are not deemed medically necessary. Specialty services must be paid for at the time of service or with pre-paid packages. See Stride's website <link to website> and Billing & Fees Sheet <link to .pdf> for details on services.

**Cancellation Policy**

• We require 48-hours notice to cancel or reschedule an appointment.

• Cancellations must be made during business hours, Monday – Friday.

o To be within the 48-hour window, cancellations made over the weekend apply to Wednesday appointments. Tuesday cancellations must be made by 5:00 on Friday.

• A fee will be charged for any appointments canceled less than 48 hours, late arrivals more than 20 minutes, or no shows.

• Fees for late cancellations, late arrivals and no shows: $125.00

**Other Charges & Payments**

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

• Delinquent accounts – An account management fee of $10 will be charged monthly 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.

Alternative payment arrangements – Payment plans are available upon request. Please contact our billing specialist at jennifer@strideseattle.com if you are unable to pay in full by due date

*INITIAL THAT YOU READ AND UNDERSTAND THE FINANCIAL POLICY ABOVE: _____*

**Informed Consent**

*I hereby authorize Stride Physio physical therapists to provide skilled physical therapy services necessary to facilitate me or my child's (if 12 or under) diagnosis or condition. These skills include examination, evaluation, diagnosis, prognosis and interventions using rehabilitative procedures, including but not limited to manual therapy, therapeutic exercise, therapeutic activities, gait training, neurodynamic techniques, decompressive cupping, taping & splinting, instrument assisted soft tissue mobilization, dry needling, blood flow restriction, and other physical agents. All procedures will be thoroughly explained prior to performing them. I recognize that there are potential risks and benefits of these procedures. It is my right to decline any part of my treatment at any time before or during treatment.*

**INITIAL THAT YOU READ AND UNDERSTAND THE INFORMED CONSENT ABOVE: _____**

**Health Insurance Portability and Accountability Act (HIPAA)**

*I understand that Stride Physio providers will use and disclose health information about the patient in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. My signature below acknowledges I am aware of my rights in accordance with HIPAA.*

**INITIAL THAT YOU WERE OFFERED A NOTICE OF PRIVACY PRACTICES: _____**

**Release of Health Information**

*We keep a record of the health care services we provide you and your child. You may ask to see and copy that record. We will not disclose you or your child's record to other 3rd parties unless we have a signed authorization form you.*

**Communication with Physical Therapists**

*Stride's portal of communication is through "Weave", where you can communicate with our front office via email, text or telephone on a HIPAA compliant platform. Specific messages to therapists will be directed to them via this portal. If your message requires more than 1 to 2 sentences to answer, then a visit will need to be scheduled (e.g., 15 minute telehealth with PT), as we cannot deliver therapy through messages. Please understand, direct messaging of therapists through their telephone or emails is not allowed as this is not HIPAA compliant.*

*Signature* _____ *Date*_____

## 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**. You are receiving this notice 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 your PHI and how you can exercise them. 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 providers 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
**Phone:** 206-547-7445 **Fax:** 206-913-2486

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 (HIPAA), 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 text or leave voice mail information on your mobile phone or home phone? ❑**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*