

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 _____



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:

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

Pelvic Medical/Health History

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Coccyx Pain | <input type="checkbox"/> Fecal or Gas Incontinence | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> IBS | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Painful Ejaculation | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Shy Bladder |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Urine Leakage |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Physical or Sexual Abuse | <input type="checkbox"/> 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

CLINIC POLICIES



Financial Policies

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 business 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 Billing

- 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.
 - *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 may provide you a superbill upon your request to submit to your insurance for possible reimbursement.
 - 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 furnish 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.
 - *Please note:* We are unable to retroactively apply self-pay discounted rates once we have billed your insurance.
 - We are unable to retroactively apply self-pay package discounts to previous visits. To receive the full discount, you must purchase the package on your first visit.
 - Self-Pay packages are not available to be shared amongst family or friends.
 - If you do not use your package within 1 year of the purchase date it can no longer be used due to price changes that occur, if you are unable to use all your visits, you must request a refund with the front desk in which case the total price will be reduced by the full price of each session.
- 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](#) for details on services.

Cancellation Policy

- We require **48 business hours notice** to cancel or reschedule an appointment.
- Cancellations must be made during business hours, Monday – Friday.
 - 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 business hours, late arrivals more than 20 minutes, or no shows.
- **Fees for late cancellations, late arrivals and no shows: \$125.00**

Other Charges and 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: _____

Informed Consent to Provide Telehealth Services

Please carefully read the following information and sign below if you consent to participate in telehealth services at Stride Physio, PLLC. and to follow the telehealth financial policy

Telehealth is the utilization of any digital audio/visual communication platform to deliver care to help manage

health. Telemedicine is a proprietary term used only by certain medical providers. Which does not include physical therapy.

Telehealth can either be live video, called synchronous, or it can be store-and-forward, called asynchronous. At Stride, you will mostly be engaging directly with your physical therapist for live interactions. However, store-and-forward may be used to demonstrate exercises, forward imaging and reports, forward home exercise programs, and the like.

Telehealth must be delivered by a licensed practitioner acting within their scope of practice on a HIPAA compliant platform that protects your personal health information. At Stride Physio, we utilize Doxy.me and Zoom.us, both of which have signed Business Associates Agreements and are HIPAA compliant.

Other HIPAA compliant platforms utilized in your treatment at Stride Physio include our electronic health record (EHR) with WebPT and our calendar/email system with Google Suite. Please note that we cannot ensure that your email system is HIPAA compliant, so please limit emails to non-health related and non-confidential information.

Stride Physio physical therapists are all licensed to provide physical therapy and wellness services to clients in Washington State. We are also licensed to provide services to people who live in the following states due to the Physical Therapy Compact laws: OR, UT, AZ, CO, ND, NE, IA, TX, OK, MO, AR, LA, KY, TN, MS, VA, NC, NH (<http://ptcompact.org/ptc-states>)

Potential risks and limits to confidentiality associated with electronic health care services include:

- ❖ Encryption privacy breach on the platform used.
- ❖ Process for documentation and storage of information
- ❖ Possibility of interruption caused by technology failure.

Should there be an interruption in communication, or failure in use of the technology, both the client and therapist will sign off and re-sign into the platform. If that fails, the office of Stride will contact you to reschedule.

All telehealth appointments should be scheduled through the Client Care Coordinators at Stride Physio (admin@strideseattle.com, 206-547-7445). Should you wish to transmit information such as medical records or imaging prior to your appointment for the therapist to review, the Client Care Coordinators will assist you with this.

Telehealth is covered by many 3rd party insurers. We will do our best to check on each policy but this information is difficult to obtain. You are advised to call on your policy to check your coverage. Should your insurance not cover telehealth, you will be responsible to pay the balance.

Payments can be made prior to your appointment time. You can pay via credit card online at <https://pay.instamed.com/strideseattle> or call our office to provide a credit card over the phone.

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 canceled less than one business day in advance will result in a \$125.00 fee charged directly to you, the patient. Missed appointments will be charged a fee of \$125.00. After three cancellations per plan of care, appointments will only be made on a weekly basis.

By providing your initials below, you understand and accept the risks associated with telehealth and you agree to participate in telehealth services and follow the telehealth financial policy with Stride Physio, PLLC. If your insurance does not cover the services, you agree to pay the balance in full.

INITIAL THAT YOU READ AND UNDERSTAND THE INFORMED CONSENT FOR TELEHEALTH SERVICES ABOVE: _____

Health Insurance Portability and Accountability Act (HIPAA) court

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.
4. 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

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.

By signing, you attest that you have read, understand, and agree to all the information and policies provided. Stride Physio, PLLC reserves the right to update these policies, and you will be notified of any changes. Your continued participation in our services signifies your acceptance of the updated policies.

Client Name _____

Date _____

Client or Guardian Signature _____