COUPEVILLE
Physical Therapy

Patient Intake Form

Patient Information:

Date _____ Patient's Name _____
(Last) (First) (MI)

Gender: M F Birth date ____/____/____ Marital Status: Single Married

Home Address: _____
(City) (State) (Zip)

Home Phone (___) _____ Cell Phone (___)_____ Work Phone (____)_____

Emergency Contact (___) _____ Name/Relationship: _____

E-mail Address_____ Soc. Sec. #_____

Would you like to have email appointment reminders? Y N **Have you received any Physical, Occupational, Speech or Massage Therapy services in this calendar year**? Y N If yes, where were the services received:

_____

Insurance Information:

Primary Insurance Co. _____ **Subscriber ID** _____ Group # _____
Subscriber Name/DOB_____ Soc. Sec. # _____

Secondary Insurance Co. _____ **Subscriber ID** _____ Group # _____

Subscriber Name/DOB _____ Soc. Sec. # _____

FOR L&I / MOTOR VEHICLE ACCIDENT CLAIMS:

Date of Injury _____ Claim # _____ Physician of Record _____
Claim Manager Name/Phone # _____
Employer Name: _____ Employer Phone # _____
Employer Address_____
(City) (State) (Zip)

Physician Information:

Referring Physician _____ Medical Group Name _____ Phone: _____

Primary Physician _____ Medical Group Name _____ Phone: _____

CURRENT/PREVIOUS HEALTH CONDITIONS

Do you have a history of the following conditions which might affect your care at physical therapy? Please circle.

Atrial Fibrillation (AFib-irregular heartbeat) Stroke Heart Attack Epilepsy

Respiratory problems Diabetes Other: _____

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PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Patient name:_____ Age: _____ Gender: _____ Height _____ Weight _____

1.	*Where is your pain/problem?*		
2.	*What caused your pain/problem*		
3.	*Approximately when did it start?*		
4.	*List at least ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again.*		
5.	*Have you ever had this same (or similar) pain/problem before? Yes___ No___ If yes, please describe)*		
6.	*In your understanding, what do you think will make it better?*		
7.	*How optimistic are you that you will get better? (circle one)*	*Fairly Mildly Fairly Very Extremely*	
8.	*What are some potential obstacles to you getting better?*		
9.	*Over the next 30 days, how many hours per week will you commit to improving your condition (following prescribed Home Exercise Program)?*		
10.	*What are you expecting from therapy?*		
11.	*On the scale, circle your pain level in the past couple of days, indicating worst, current and best.*	*Mild Moderate Severe* *0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10*	
12.	*List any medications you are taking (attach list if necessary)*		
13.	*List all past surgeries with approximate year.*		
14.	*List all medical conditions you have (including allergies, potential pregnancy).*	*Examples: sulfa, pollen,...*	
			total

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____

Pain Drawing

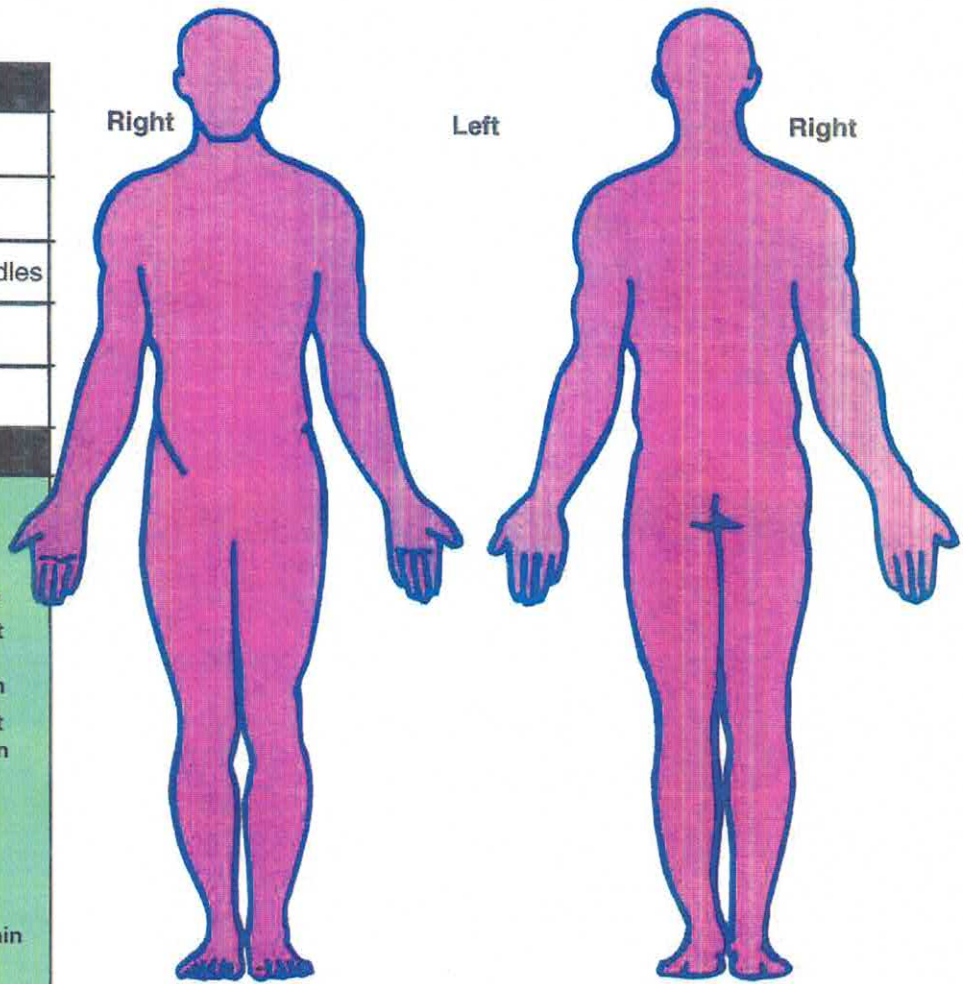
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensley severe pain
10	Unbearable pain; requires urgent medical treatment



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

www.aapmr.org

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CONSENT & RELEASE FORM

Appointments - We operate as a team at CPT. Your individual plan of care may include exposure to additional clinicians other than your evaluation physical therapist. This is meant to promote a full spectrum of quality care. During your visits, if there are any expectations not met or exceeded, please notify your primary therapist or the front desk and we will address the issue promptly.

Cancellations & No-shows – Everyone has unexpected conflicts now and then, but timely attendance of your scheduled appointments is critical to your recovery success. Cancellations and no-shows not only hinder our scheduling capabilities, but most importantly, they delay the healing process that you are here for.

Timeliness & Attention – We value your time and don't want to keep you waiting. Occasionally we are delayed by an unexpected event, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time so other patients will not have to wait. Your full attention and commitment to getting the most out of your appointment time is critical. Please do not bring young children to your appointment and please limit cell phone use to emergent situations.

Financial Policies - We are happy to bill most insurance companies. We will do our best to verify whether outpatient physical therapy is covered by your insurance plan, and to determine the extent of coverage but ultimately it is your responsibility to know the limits and coverage of your own insurance plan. If payment is denied by the insurance company after you have received treatment, you are responsible for the balance on your account. If we find that your insurance plan does not cover physical therapy, we will do our best to work out a solution with you to enable you to receive the treatment that you need.

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

If you have any questions about financial policies or need assistance with your bill or insurance, please call and ask for the billing manager at 360-293-2417. Please advise us as soon as possible of any changes that may affect your billing, i.e., address/contact information, employment, new injury or any insurance changes.

PATIENT CONSENT AND RELEASE

I hereby consent to treatment by Coupeville Physical Therapy.

I understand that my appointments are subject to change, and that I may be scheduled with any licensed clinician at CPT.

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 Coupeville Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Coupeville Physical Therapy for any benefits available under my insurance plan.

I understand that Coupeville Physical Therapy is not responsible for any personal belongings I bring to the clinic.

I acknowledge that I have read and understand the cancellation, no-show and financial policies as stated above.

Patient Signature: _____ Date: _____
(Parent or guardian's signature if patient is under 18)

I also consent to having my photograph taken to be kept on file for patient identification purposes only.

Patient Signature: _____ Date: _____
(Parent or guardian's signature if patient is under 18)

COUPEVILLE PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact Carla Derie, Operations Manager,
***herein after referred to as "designated privacy official/contact person"** at 360-299-2781*
3001 R Avenue, Suite 110, Anacortes, WA 98221

This notice describes the procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of your health information.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, the doctor who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health problems that could complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the doctor. We do this to provide the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your doctor and getting needed information. Family members and other health care providers may be part of your physical therapy outside this office and that may require us to provide information about you.
- **For payment**. We may need to disclose health information about you in order to bill your health plan or insurance company or other third party for your treatment in this clinic. We may also need to tell your health plan or insurance company about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will pay for the treatment.
- **For Health Care Operations**. We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain treatments are effective for certain problems. We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.
- **Appointment Reminders**. We may contact you to remind you of your appointment. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive these communications, we will not use or disclose your information for these purposes.
- **Treatment Alternatives**. We may tell you about or recommend possible treatment options or alternatives that may interest you.
- **Health-Related Products and Services**. We may tell you about health-related products or services that may interest you.

OTHER CIRCUMSTANCES

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of state and other law:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies 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 health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed.
- In situations where you are not capable of giving consent (due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.
- **Non-Custodial Parent.** We may disclose health information about a minor child equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.

OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you sign an *Authorization* for us to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our

designated privacy official/contact person in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Correct.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as the information is kept by this office. To request a correction, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our *designated privacy official/contact person.* We will provide you with one of these forms at your request. We may deny your request for an amendment if your request is 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 correct information that:
  - We did not create, unless the person or entity that created the information is no longer available to make the correction
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a record of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written authorization. To obtain this accounting, you must submit your request **in writing** to our *designated privacy official/contact person.*. It must state the time period for which you want an accounting. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). 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. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our *designated privacy official/contact person*. We will provide you with one of these forms at 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. For example, you can ask that we only contact you at work or by mail or e-mail. To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our *designated privacy official/contact* person. 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 a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our *designated privacy official/contact person*.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and 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 the current notice or a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our *designated privacy official/contact person.* ***You will not be penalized for filing a complaint.***

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(To be retained by Medical Provider)

I understand that Coupeville Physical Therapy (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to/or consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area [optional: and available on website at . . . .]

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____