



**ANACORTES**  
PHYSICAL THERAPY

Dear Valued Patient and Friend,

Welcome to Anacortes Physical Therapy! You have many options when it comes to your personal health care, and we thank you for choosing us. Our highly qualified and experienced providers take pride in delivering personalized care and the outstanding results that you deserve.

As health care professionals, we have a responsibility to your physician, your insurance company, and ultimately to YOU to establish a relationship of mutual respect and trust. In turn, we need a commitment on your part as our patient and friend to help us in the following areas:

- ✚ If you are responsible for a co-pay, please make every effort to bring it on each day of service, or pay several in advance.
- ✚ Everyone has unexpected conflicts now and then, but *timely attendance of your scheduled appointments is critical* to your length of recovery time. Cancellations and no-shows not only hurt our business and prevent others from being scheduled in your place, but more importantly, they delay the healing process that you are here for.
- ✚ Your full attention and commitment to getting the most out of you appointment time is critical. Please refrain from cell phone use and other distractions.
- ✚ We truly understand that most people do not enjoy filling out paperwork. However, each bit of information requested (*even if you are a returning patient*) is information needed for our billing operations, information management, or documentation needs. We ask that you fill out each form entirely to the best of your ability.

Our patients' feedback, opinions, and suggestions are very important to us. At the completion of your treatment, please visit our website at [www.anacortespt.com](http://www.anacortespt.com) and complete our patient satisfaction survey. Not computer savvy? Just ask the front desk for a copy.

Thank you,

Greg Fritz, PT  
Owner, Anacortes Physical Therapy



# NOTICE OF PRIVACY PRACTICES

Effective Date: July 1, 2003

**Anacortes Physical Therapy**  
3001 R. Ave. Suite 110  
Anacortes, WA 98221 (360) 299-2781

## **THIS NOTE 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 the accounts manager at (360) 299-2781.

#### **WHO WILL FOLLOW THIS NOTICE**

This notice describes *Anacortes Physical Therapy* and that of:

- 1) Any health care professional authorized to enter information into your chart.
- 2) All departments of the practice.
- 3) Any member of a volunteer group at our practice.
- 4) All employees, staff and other practice personnel.

All these entities follow the terms of this notice. In addition, these entities may share health information with each other for treatment, payment, of health care operations purposes described in this notice.

#### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

Washington State Law governs a patient's right of access to their healthcare information maintained by a healthcare provider. We are required by law to:

- 1) Make sure that your medical information is kept private.
- 2) Give a notice of our legal duties and privacy practices with respect to your medical information.
- 3) Follow the terms of the notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION AS FOLLOWS:**

All of the ways we are permitted to use and disclose information will fall within one of the following categories.

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to other staff who are involved in taking care of you in our practice. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party.

**For Health Care Operations:** We may use and disclose medical information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. We may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who our specific patients are.

**To Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care.

**For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.

**As Required By Law:** We will disclose information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** Any disclosure of your health information would only be to someone who was able to help prevent a threat against the health or safety of any individual.

#### **SPECIAL SITUATIONS**

**Military and Veterans:** If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**To Comply with Worker's Compensation Laws:** If you make a worker's compensation claim, we may release information about you to anyone who is working with your claim.

**For Public Health Risks:** We may disclose medical information about you for public health activities. These activities generally include the following:

- 1) To prevent or control disease, injury or disability.
- 2) To report births or deaths.
- 3) To report child abuse or neglect.
- 4) To report reactions to medications or problems with products.
- 5) To notify people of recalls of products they may be using.
- 6) To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease.
- 7) To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make the disclosure if you agree or when required or authorized by law.

**For Health Oversight Activities as Authorized by Law:** These activities are necessary for the government 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 your medical information in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.

**For Law Enforcement:** We may release your information for purposes such as when we receive a subpoena, court order, or other legal processes. We may also release your information if you are a victim of a crime or have been involved in a crime.

**To Coroners, Medical Examiners, and Funeral Directors:** We may release your medical information consistent with applicable laws allowing these people to carry out their duties.

**To Authorized Federal Officials for National Security and Intelligence Activities:** We may release your medical information about you for intelligence, counterintelligence, and other national security activities authorized by law.

**To Authorized Federal Officials for Protective Services for the President and Others:** We can disclose your information to authorized federal officials so they may provide protection to the President or any other authorized individuals.

**To Correctional Institutions if you are in Jail or Prison:** We may release your medical information as necessary for your health and the health and safety of others.

#### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

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

**Right to Inspect and Copy:** You have the right to inspect and copy information that may be used to make decisions about your care. Usually, this includes medical and billing records.

You must submit your request in writing to Anacortes Physical Therapy. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. The cost of copying will be given to you upon your request of copies. You will receive your copy within 15 days of receipt of your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice.

Your request must be made to us in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it 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 amend information that:

- 1) Was not created by us, unless the party that created the information is no longer available to make the amendment.
- 2) Is not part of the medical information kept by this practice.
- 3) Is not part of the information, which you would be permitted to inspect and copy.
- 4) Is accurate and complete.

Any amendment made to your information will be disclosed to those with whom we disclose information as previously specified.

You have the right to request a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

You must submit your request in writing to Anacortes Physical Therapy. Your request must state a time period, which may not be longer than seven years and may not include dates before April 14, 2003. 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.

**Right to Request Restrictions:** You have the right to restrict certain uses and disclosures of your health and billing records. You must deliver this request in writing to us.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. However, we are not required to agree with 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.

You must make your request to us in writing. 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 Paper Copy of this Notice:** You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, contact Anacortes Physical Therapy at (360) 299-2781.

#### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right 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 a copy of the current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

#### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the accounts manager at (360) 299-2781. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I acknowledge receipt of a copy of the Anacortes Physical Therapy "Notice of Privacy Practices."

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date



# CONSENT & RELEASE FORM

## CANCELLATIONS AND NO-SHOWS

Cancellations or changes must be made by the day prior to the scheduled appointment. If a patient fails to show for three (3) scheduled appointments or cancels an excessive number of times, physical therapy will be discontinued and no further appointments will be scheduled until we are notified by their physician.

## TIMELINESS

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected event with another patient, 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.

## FINANCIAL POLICIES

We are happy to bill many insurance companies. Please ask the front desk if you need to verify that we can bill your insurance company. We will do our best to verify whether outpatient physical therapy is covered by your insurance plan, and to determine the extent of coverage. 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.

We do bill secondary insurance plans, except for Medicare supplementary plans which are forwarded to the insurer by Medicare. You are responsible for anything that your insurance(s) don't cover.

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

Payment must be made either at the time services are rendered or upon the receipt of your bill in the mail unless you contact us to make other arrangements. We are very willing to work out a payment schedule with you if your financial situation will not let you pay the full balance. If you do not contact us and your account is seriously past due, it may be turned over to collections.

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, employment, new injury or insurance changes.**

## PATIENT CONSENT AND RELEASE

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

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 Anacortes Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Anacortes Physical Therapy for any benefits available under my insurance plan. This information includes any photos taken during treatment.

I hereby consent to treatment by Anacortes Physical Therapy.

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 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)





## Condition/Injury Information

Name: \_\_\_\_\_

Reason for seeking physical therapy services: \_\_\_\_\_

When did your injury/problem begin?      Within 2 weeks: \_\_\_\_\_      Date: \_\_\_\_\_      Other: \_\_\_\_\_

Is this visit because of an injury?       YES  NO

How did this injury occur?       Work       Auto Accident       Home       Recreation       Other

a. Have you ever been injured or suffered previous pains/problems in the area(s) before this injury?

YES  NO      If yes, when? \_\_\_\_\_

b. Have you had a recent X-ray, CT or MRI of the injured area?       YES       NO

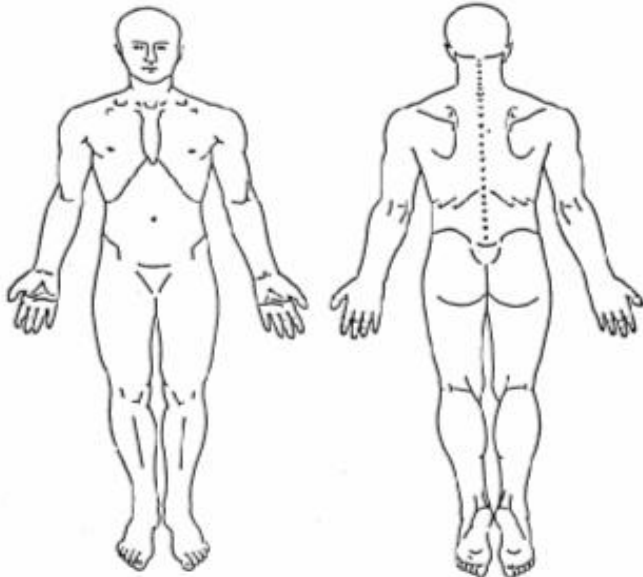
When? \_\_\_\_\_      Where? \_\_\_\_\_

c. Did you recover from this injury?       YES       NO

From the list below, please check those activities that you are either unable to perform in a normal fashion or have difficulty performing because of your pain/problem.

	<u>Difficult</u>	<u>Unable</u>		<u>Difficult</u>	<u>Unable</u>
Sit	( )	( )	Housework	( )	( )
Stand	( )	( )	Yard Work	( )	( )
Walk	( )	( )	Twist	( )	( )
Push	( )	( )	Bend	( )	( )
Pull	( )	( )	Squat	( )	( )
Lift	( )	( )	Drive	( )	( )
Stretch	( )	( )	Ride in a Car	( )	( )
Climb	( )	( )			

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain not related to your present injury or condition.



/// : Stabbing      XXX : Burning      +++ : Achey  
OOO : Pins & Needles      === : Numbness

Please rate your major area of pain on the 0-10+ Pain Rating Scale. Remember, the numbers refer to your pain, not how strong or weak you feel. For example: No. 1 is very weak pain and No. 7 is very strong pain.

Your Pain Rating now: \_\_\_\_\_ Over past 30 days: \_\_\_\_\_  
Best day: \_\_\_\_\_ Worst day: \_\_\_\_\_

Please mark a line on scale indicating pain today:

No pain at all \_\_\_\_\_ Pain as bad as can be

Comments: