P: 206 604 4707
F: 206 367 9203

HOLISTIC ORTHOPEDICS

seattlewellness@me.com
holistic-orthopedics.com

PATIENT & INSURANCE INFORMATION

Last Name:_____ First Name: _____ MI: _____
Address: _____
City:_____ State:_____ Zip:_____
Birthdate: _____ Sex: F M
Phone #:_____ E-mail:_____
Doctor: _____ Dr. Phone #_____
Emergency Contact Name:_____ Relationship to patient:_____
Home phone #:_____ Cell phone #:_____ E-mail:_____

Responsible party information, if different from patient:

(This office offers the courtesy of Insurance Billing, however, we do not have a contract with all companies.)

Last Name:_____ First Name: _____ MI:_____
Address:_____
City:_____ State:_____ Zip:_____
Employer: _____ Employer name:_____

Insurance Information:

Primary Insurance

Insured's Last Name:_____ First Name:_____ MI:_____

Insured's Birthdate: _____ Sex: F M Relationship to patient:_____

Insurance Co.:_____ Cust. Service Phone#:_____

Optional if current insurance card is presented.

Insurance Co. Address:_____
Member ID # _____ Group #_____ Plan #_____

If L&I: Claim # _____ Date of Injury:_____
Claims Manager:_____ Claims Mgr. Phone# _____
If Motor Vehicle Accident: Claim#_____ Date of Accident: _____
Claims Manager: _____ Phone #_____

I understand, as the patient and/or above mentioned responsible party, that I am fully responsible for payment of all charges incurred. I understand that, where appropriate, credit bureau reports may be obtained.

I authorize my insurance benefits to be paid directly to the Holistic Orthopedics for services rendered. I understand I am financially responsible for any deductibles, non-covered services, or non-authorized services. I authorize Holistic Orthopedics to release any information requested by the insurance company with regard to payment of benefits.

Late Cancel, No-Show and Late Arrival Policy
Cancellations made with less than 24 hours notice (1 business day) and no-shows, will incur a $75 fee for a 1hour session and a $100 fee for a 1 ½ hour session. Late arrivals of 15 minutes or more may result in the cancellation of your session and a no-show fee per above guidelines. I understand the Late Cancel, No-Show and Late Arrival Policy. If incurred, I agree to pay these fees.

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MEDICAL HISTORY

1. Please list any significant past injuries or surgeries relevant to the condition for which you seek Therapy:

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

2. Have you had any tests for your current symptoms? Yes No

If yes, check: X-ray Bone Scan CAT Scan MRI Nerve Conduction Test
Other: _____
Results: _____

3. Do you currently have or have you had a history of the following:

AIDS	Artificial Joints	Heart Murmur
Allergies	Asthma	Heart Trouble
Anemia	Cancer Treatment	High Blood Pressure
Arthritis	Cardiac Pacemaker	Psychiatric Treatment
Artificial Heart Valves	Diabetes	Stroke

4. Are you currently taking medication for this or any other medical problem? Yes No
If yes, please list. If needed, attach a separate sheet for medications:

_____

SUBJECTIVE EVALUATION

1. What is your primary complaint? _____

2. Describe how and when your symptoms began: _____

_____

3. Mark on the scale, your average level of pain at rest: 0 1 2 3 4 5 6 7 8 9 10
Mark on the scale, your average level of pain with activity: 0 1 2 3 4 5 6 7 8 9 10

0 = No pain at all
10 = Worst pain imaginable

4. What aggravates your symptoms? _____
5. What eases your symptoms? _____
6. If appropriate, comment on the following:
How do symptoms change in the AM? _____
Throughout the day? _____ In the evening? _____

7. Overall how have your symptoms progressed? Getting better Unchanged Getting worse
Explain how: _____

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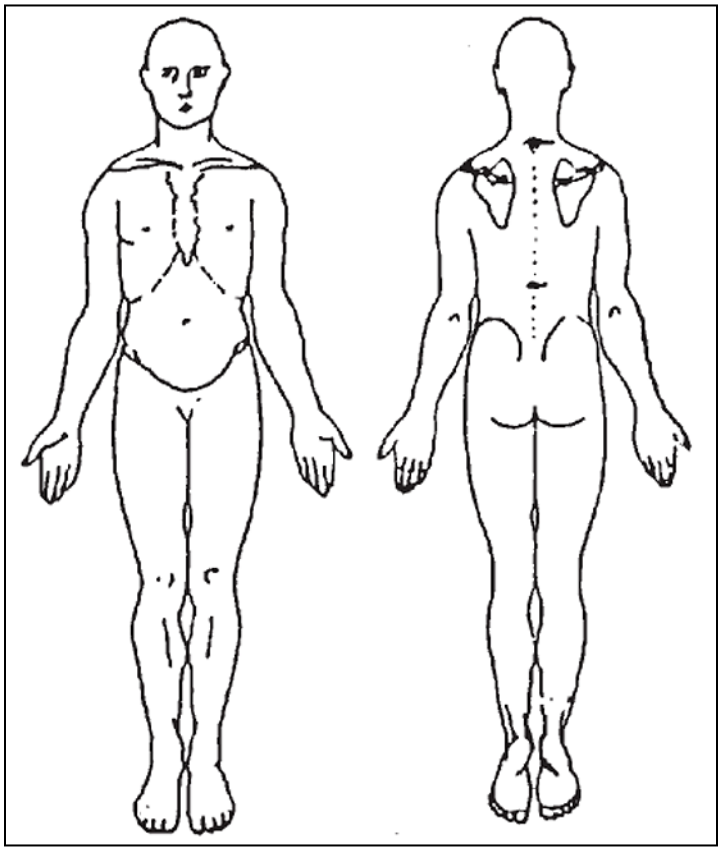
8. Have you had treatment for your current symptoms? Y N
If yes, describe treatment and results: _____

9. On the body chart below, please mark your symptom areas (you'll need to print it out to complete the diagram):



10. What is your work/hobby?
Work: _____
Hobby: _____

11. Are you currently working? Yes No
If no, is it because of your symptoms? Yes No

12. Describe the physical demands of your work:
Heavy Moderate Light Sedentary
Specifics: _____
_____

13. Describe the physical demands of your recreational activities or hobbies:_____
_____

14. Are you able to participate in your recreational activities or hobbies: Yes No
If no, explain: _____
_____
_____

15. Are you having difficulty performing your daily activities? Yes No
If yes, explain:_____
_____

16. What do you think is the cause of your symptoms? _____
_____

17. What are your goals for Therapy? _____
_____

The above information is true and complete, to the best of my knowledge. (print to sign)

Signature of Patient / Guardian: _____ Date:_____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date:_____

Signature of minor :_____ Date _____

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NOTICE OF PRIVACY PRACTICES

(Required by law)

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and individually identifiable health information used, or disclosed by us, be kept properly confidential. As required by "HIPAA", following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **Treatment** – providing, coordinating, or managing health care and related services by one or more health care providers.

- **Payment** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities,
and utilization review.

- **Health care operations** – include the business aspects of running our practice, such as conducting quality assessment
and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a staff member of the Holistic Orthopedics.

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to request a copy of our current *Notice of Privacy Practices* at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.

Signature of Patient / Guardian (print to sign): _____ Date:_____

For the treatment of minors: I hereby grant permission for Therapy to be performed on this minor.

Parent Signature: _____ Date:_____

Signature of minor: _____ Date _____

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E-MAIL DISCLOSURE AND CONSENT FORM

Holistic Orthopedics offers patients the opportunity to communicate by e-mail. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with Holistic Orthopedics via e-mail without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of e-mail communication cannot be guaranteed.
- Online services and your employer may have a legal right to inspect and keep e-mails that pass through their system.
- E-mail is easier to falsify than handwritten or signed hard copies. In addition, it is difficult to verify the true identity of the sender, and to ensure that only the recipient can read the e-mail once it has been sent.
- E-mails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- E-mail can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of Holistic Orthopedics or the patient. E-mail senders can easily misaddress an e-mail, resulting in it being possibly sent to many unintended and unknown recipients.
- E-mail is indelible. Even after the sender and recipient have deleted their copies of the e-mail, back-up copies may exist on a computer or in cyberspace.
- Use of e-mail to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- E-mail can be used as evidence in court.

Conditions of using e-mail

Holistic Orthopedics will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Holistic Orthopedics cannot guarantee the security and confidentiality of e-mail communications. Thus, patients choosing to communicate with Holistic Orthopedics via e-mail, must consent to the use of e-mail communication with our clinic.

- E-mails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
  Holistic Orthopedics may forward e-mails internally to the Holistic Orthopedic's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. Holistic Orthopedics will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
  E-mail communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on e-mail sent to Holistic Orthopedics and for scheduling appointments where warranted.
- *If the patient's e-mail requires or invites a response from Holistic Orthopedics* and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The patient should not use e-mail for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abused. Similarly, Holistic Orthopedics will not discuss such matters over e-mail.
- The patient is responsible for informing Holistic Orthopedics of any types of information the patient does not want to be sent by e-mail, in addition to those set out in the bullets above. Such information that the patient **does not want communicated over e-mail** include:

_____

_____

The patient can add to or modify this list at any time by notifying Holistic Orthopedics in writing.

- Holistic Orthopedics is not responsible for information loss due to technical failures associated with the patient's e-mail software or Internet provider.

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Instructions for communication by e-mail

To communicate by e-mail, the patient shall:

- Limit or avoid using an employer's or other third party's computer.
- Inform Holistic Orthopedics of any changes in the patient's e-mail address.
- Include in the e-mail: the category of the communication in the e-mail's subject line, for routing purposes (e.g., 'appointment request'); and the name of the patient in the body of the e-mail.
- Review the e-mail to ensure clarity and that all relevant information is provided before sending to Holistic Orthopedics.
- Inform Holistic Orthopedics when the patient receives an e-mail from the staff of Holistic Orthopedics.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by e-mail or written communication to Holistic Orthopedics.
- **Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on e-mail**. Rather, the patient should call Holistic Orthopedics' office for consultation or an appointment, visit Holistic Orthopedics' office or take other measures as appropriate.

Although Holistic Orthopedics will endeavor to read and respond promptly to an e-mail from the patient, **Holistic Orthopedics cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient should not use e-mail for medical emergencies or other time-sensitive matters.**

Patient acknowledgement and agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Holistic Orthopedics and me, and consent to the conditions outlined herein, as well as any other instructions that Holistic Orthopedics may find necessary to communicate with patients by e-mail. I understand that Holistic Orthopedics does not use encryption software. I acknowledge Holistic Orthopedics' right to, upon the provision of written notice, withdraw the option of communicating through e-mail. Any questions I may have had were answered.
Patient signature_____ Patient name_____ Date_____

PATIENT COMMUNICATION CONSENT FORM
I agree to allow Holistic Orthopedics to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Holistic Orthopedics to leave messages for me when I am unavailable.

Method	Messages (circle)		Number/Address
Home phone	Yes	No	
Cell Phone	Yes	No	
Work Phone	Yes	No	
Alternate Phone	Yes	No	
Text Messages	Yes	No	
Email	Yes	No	

By my signature below, I acknowledge that I have read and understand the Patient Communication Consent Form and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting.

Signature _____ Printed Name _____Date _____

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Statement of Patient Financial Responsibility

Holistic Orthopedics appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for knowing these stipulations and paying for any amounts not covered by your insurer. We urge you to be your own health advocate, and know your insurance benefits. If your insurance carrier denies any part of your claim, or if you or your therapist elects to continue past your approved period, you will be responsible for your balance in full. For your convenience, we accept cash, checks, and most major credit cards. You can also pay on our website, www.holistic-orthopedics.com/patient-resources, or mail in a check. Payment is expected by payment due date on your Patient Statement.

I have read the above policy regarding my financial responsibility to Holistic Orthopedics, for providing occupational therapy services to me. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Holistic Orthopedics. I agree to pay Holistic Orthopedics the full and entire amount of all bills incurred by me, if applicable, any amount due after payment has been made by my insurance carrier. I understand I am financially responsible to Holistic Orthopedics for charges not covered by this authorization.

Patient Signature _____ Date _____