

Dear New Patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing our physical medicine and rehabilitation clinic. It is our goal to assist you in recovery and restoration from your musculoskeletal and neurological health issues. We wish to make your visits informative and your experience pleasant and rewarding.

If your visit is scheduled to occur 4 or more days out from your call to our office, you should receive a confirmation letter and brochure in the mail in advance of being seen. Whether you do or do not get the brochure in advance, we encourage you to learn more about physiatry, our services and our providers by thoroughly browsing the website ([www.nwphysiatry.com](http://www.nwphysiatry.com)).

Expect to be here for 1.5 to 2 hours for your initial visit. It takes staff about 20 minutes to build your electronic medical record from your completed paperwork, and another 10 minutes to take your vitals and to get you roomed and ready to see the physician. Time with Dr. Cantini is usually 45-60 minutes.

Your arrival time for your initial visit is set to allow you to complete your new patient paperwork. If you complete all of this paperwork in advance, you may arrive 15 minutes past the time you were given by our staff when you scheduled.

This set of new patient paperwork documents includes:

- Responsibilities notification
- Financial Policies notification
- Patient Registration forms
- Medical history forms
- Notice of Privacy Practices

It is important that you bring the following with you to your appointment:

- Completed new patient paperwork
- Insurance card(s), payment coupons, complete claim information, or full payment if self-pay
- Valid driver's license or passport (if you have neither, please call us in advance to discuss alternatives)
- List of current prescription and over the counter medications and vitamins that includes dosage
- Payments that are due at the time of service (co-payments or self-pay payments)

We encourage you to make a list of any questions you may have. You will find we are dedicated to excellence in patient care. During your appointment we will review your medical history, perform a physical exam and discuss the goals for your visit and future care.

We look forward to participating in your health care needs.

*Specialists in electrodiagnosis and rehabilitation medicine*

To: All Patients  
From: Maureen Miller, practice manager  
Re: Responsibilities

Patients, providers and healthcare organizations all come with expectations when entering into a physician/patient relationship. It is my intention to be clear about expectations to promote a winning relationship for all.

Please be informed that it is the desire of Northwest Physiatry Associates to serve our patients well with regard to providing quality service at all levels of the organization. If at any time you feel that we have failed in doing this; please let me know so that we can learn how to do better.

Patients are expected to partner with their providers and the organization in their healthcare. Partnering with providers involves providing accurate and complete information as requested, follow-through with physician treatment plans and office visit scheduling. Partnering with the organization involves respectful treatment of staff and physician's time as well as timely payment of all charges.

The following behaviors negatively impact our ability to assist you in your healthcare needs and may result in discharge from care:

- Three late cancellations / no shows for established patients, two for new patients
- Failure to follow through with testing / therapy as directed
- Failure to come in for routine office visits when under medication or other therapy
- Failure to comply with the narcotics agreement
- Hostile, or otherwise inappropriate treatment of provider or staff
- Failure to pay your account balance before being sent to collections

Good communication with your provider and our staff is necessary to ensure everyone is on the same page with regard to your services. If you feel changes are needed in your scheduling, treatment plan, medications or billing please contact us promptly.

Received: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### Financial Policies

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

**General:** Patients are responsible for payment of all charges for services rendered regardless of insurances. Co-payments for those with private insurance are due at the time of service. We will bill your insurance for additional charges, and then bill you for the all remaining charges allowed by our contract with the insurance carrier. We expect payment within thirty days on this balance due.

We require all patients to release insurance carriers to issue payment directly to Northwest Physiatry Associates for services rendered.

**Assignment and Release:** I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for the balance due. I also authorize the doctor or insurance company to release any personal information required for payment of this claim.

**Cancellations:** Please contact us 48 or more hours in advance when you need to cancel or reschedule an appointment. A \$25 fee will be assessed on all cancellations occurring less than 48 hours in advance.

**Form Completion:** There is a \$25 self-pay charge assessed for completing forms not paid by insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Accident Patients (motor vehicle or personal injury):** \$150.00 deposit is due at the time of service for your initial visit, this deposit will be fully refunded within 30 days of receiving payment for the initial visit. We bill first party personal injury protection policies only. If you have only second or third party personal injury protection, you will need to be seen as a self-pay patient. Personal injury protection has a limit to what it pays per claim. We will expect you to keep us informed of your account balance so that your care does not exceed the limits unexpectedly. If your care exceeds the limits of your policy, we will bill your private insurance or place you on the self-pay plan if there is no other insurance.

**Self Pay:** Self pay patients are required to make a large payment in advance towards services the initial visit. This payment is not to be thought of as total charges for the visit. Actual charges for your first visit can range from \$160.00 to \$319.00. Actual charges for subsequent visits can range from \$65.00 to \$220.00, with \$90.00 to \$154.00 being the most common. Charges are based on both the length of your visit and the complexity of your issues. Payment in advance of treatment for first visits is \$150.00; payment in advance of treatment for subsequent visits is \$75.00. You will be billed for additional balances due; payment is expected with 30 days.

**Self Pay Agreement:** I have no medical coverage or choose to bill my insurance directly. I agree to pay Northwest Physiatry Associates according to their self pay policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Registration

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_  Male,  Female

Last Name: \_\_\_\_\_  Married,  Single,  Divorced,  Widowed

Address 1: \_\_\_\_\_  American Indian/Alaska Native,  Native Hawaiian/Pac Islander

Asian,  Black or African American,  White,  Other Race

Address 2: \_\_\_\_\_  Hispanic or Latino,  Not Hispanic or Latino

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Right handed,  Left handed,  Ambidextrous

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Here to see Dr:  Cantini  Chatilo Work:  Full-time,  Part-time,  Self employed,  Student  
 Unemployed,  Military duty  Retired

Referring Dr: \_\_\_\_\_

Employer: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary language: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

I am:  hard of hearing  need assistance from the curb

I acknowledge it is the policy of NW Physiatry to download my medication history from my pharmacy. \_\_\_\_\_.

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Who is the subscriber on your insurance policy:  spouse  parent  self (you may skip past the remainder of this section)

Name of subscriber if not yourself: \_\_\_\_\_

subscriber's address and home phone is the same as mine Subscriber's employer: \_\_\_\_\_

subscriber's address is different: Subscriber's SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Please list an emergency contact:  Male  Female

Name: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Address 1: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Relationship to you:  Spouse,  Significant Other,  Parent,  Son/Daughter,  Friend,  Other \_\_\_\_\_

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Who should we bill before billing you?: \_\_\_\_\_

Is this visit related to a:  work injury  motor vehicle accident  accident, not work or auto related, occurring @ \_\_\_\_\_

Date of accident/injury: \_\_\_\_\_ If work related, who is the Workers' Compensation Carrier: \_\_\_\_\_

Policy or Claim #: \_\_\_\_\_ Patient's Policy # suffix: \_\_\_\_\_

Group name/number: \_\_\_\_\_ Subscriber's Policy # suffix: \_\_\_\_\_

Payer Tel#: \_\_\_\_\_ Secondary insurance:  yes  no

Secondary insurance carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Patient's Policy # suffix: \_\_\_\_\_

Group name/number: \_\_\_\_\_

Subscriber's Policy # suffix: \_\_\_\_\_

Policy Tel#: \_\_\_\_\_

Third insurance:  yes  no

Tertiary (third) insurance carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Patient's Policy # suffix: \_\_\_\_\_

Group name/number: \_\_\_\_\_

Subscriber's Policy # suffix: \_\_\_\_\_

Policy Tel#: \_\_\_\_\_

How did you first hear about us?

- friend or family member
- internet search engine
- referring doctor
- online phone book
- paper phone book
- radio
- Seattle Magazine
- brochure
- other: \_\_\_\_\_

If you were referred to us by a patient, and are comfortable with us acknowledging that you came to see us, we would like to know who that person is to send them a thank – you. To do so, we need you to tell us below who they are:

Name of friend or family: \_\_\_\_\_ May we send a thank you?  yes  no

Have you heard of us through other, less influential means as well? If so, how:

- friend or family member
- internet search engine
- referring doctor
- online phone book
- paper phone book
- radio
- Seattle Magazine
- brochure
- other: \_\_\_\_\_

Please list all known allergies:

\_\_\_\_\_

\_\_\_\_\_

More:  no  yes (list on back of page)

Auto, work and personal injury related cases are assigned claim managers. If you are here as a result of one of these please provide:

Claim Manager's Name: \_\_\_\_\_ Claim Manager's Tel#: \_\_\_\_\_

Please read our Privacy Practices Notice! **Unless you direct us not to do so**, we assume permission granted to leave voice mail messages on your home and cell phone pertaining to your upcoming appointments and ongoing care. **We also assume permission** to disclose information to the spouses of married patients.

- I, patient, have read and understand this policy. \_\_\_\_\_ initials
- Do not leave messages on my home phone (does not include cell phone). \_\_\_\_\_ initials
- Do not leave messages on my cell phone. \_\_\_\_\_ initials
- Do not disclose information to my spouse (if married). \_\_\_\_\_ initials

Northwest Psychiatry Staff:

Please check off all the items below after briefly explaining each to the patient:

- HIPAA Privacy Practices Notice
- Late Cancellation/No-show Policy
- Financial Policy
- Staff initials: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Specialists in electrodiagnosis and rehabilitation medicine

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Occupation: \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

**Initial Visit Intake Form, pg 1:** Please provide all the following medical information to the best of your ability.

- Male  
 Female

Age: \_\_\_\_\_

**What is the primary reason for your visit today?**

\_\_\_\_\_

List what other issues, if any, you would like to discuss with the doctor if time allows

\_\_\_\_\_

**Medicines:** Are you allergic to or have had a bad reaction to any medicine or any other substance?

- Yes  No

If yes please list the medicine(s)/substances

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Dr, please see next page. I needed more room.*

What prescription drugs are you currently taking?  None.  
(Please list name, dose and frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Dr, please see next page. I needed more room.*

Do you take any non-prescription medicines or tonics? For example, vitamins, herbal supplements, laxatives, diet pills, antacids, ibuprophen, sinus or cold tablets?  Yes  No

If yes please list the medicine(s)/substances

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Dr, please see next. I needed more room.*

**Hospitalizations:** Please list all of your hospitalizations.

No hospitalizations

Reason/surgery	Place	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Dr, please see next page. I needed more room.*

## YOUR HEALTH HISTORY

Do you, or have you had any of the following:

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (Circle: type I / type II)       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure)        |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cholesterol problems                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to food or environs             |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other respiratory problems                |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorder / uncontrolled bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, jaundice, hepatitis        |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach or intestinal problems            |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological problems                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental health problems                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease (VD)                     |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS (HIV)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious injury or accident                |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical / sexual abuse                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse (drug or alcohol)         |

Other illnesses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SOCIAL HISTORY

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Smoke now or in your past?  |
|                          |                          | <input type="checkbox"/> Pipe, <input type="checkbox"/> Cigar, <input type="checkbox"/> Cigarettes  |
|                          |                          | How long? _____, How much? _____  |
|                          |                          | Have you quit? <input type="checkbox"/> No, <input type="checkbox"/> Yes, when? _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol?   |
|                          |                          | <input type="checkbox"/> Beer, <input type="checkbox"/> Wine, <input type="checkbox"/> Hard liquors |
|                          |                          | Amount per week? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Use recreational drugs?   |
|                          |                          | Type? _____, How much? _____  |

\_\_\_\_\_ Hours of sleep per night, \_\_\_\_\_ meals per day

Other: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

- | Yes                      | No                       | Who (M mother, F father, S sibling, G grandparent, C Child) |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Heart problems / murmurs                              |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Diabetes  |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Allergy   |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Cancer  |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Bleeding disorder                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ Alcohol, substance, sexual abuse                      |

Other: \_\_\_\_\_  
\_\_\_\_\_

See dictation Reviewed by: \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

**Initial Visit Intake Form, pg 3:** Please provide all the following medical information to the best of your ability.

**REVIEW OF SYSTEMS**

Please indicate by checking the appropriate boxes if you have never, did in the past, or are currently experiencing any of the symptoms listed below..

**GENERAL**

	Never	Past	Current
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't stand hot weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't stand cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ALLERGY**

Environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NEURO**

Frequent loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells (black outs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions (seizures, fits, epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor (shaking, tumbling)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness (body parts "go to sleep")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EYES**

Eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ENT**

Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear or hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nose trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem snoring / apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**RESPIRATORY**

Daily cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily coughing of phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CARDIAC**

Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg vein trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg pain when walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GI**

	Never	Past	Current
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids (Piles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GU**

Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HEME/LYM**

Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ENDO**

Feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MSK**

Joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PSYCH**

Physical / sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression (feeling blue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble getting along with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

See dictation      Reviewed by: \_\_\_\_\_



## **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.**

Northwest Physiatry Associates respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

Examples of uses and disclosures of protected health information for treatment, payment, and health care operations:

### **For treatment:**

- Information obtained by a physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

### **For payment:**

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

### **For health care operations:**

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

- We may use and disclose your information to conduct or arrange for services, including:
- Medical quality review by your health plan;
- Accounting, legal, risk management, and insurance services; and
- Audit functions, including fraud and abuse detection and compliance programs.

### **Your health information rights**

The health and billing records we create and store are the property of Northwest Psychiatry Associates. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”).
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:

Medical Records Clerk  
1530 N 115<sup>th</sup> ST #305  
Seattle, WA 98133  
206 362-2464

## **Our responsibilities**

### **We are required to:**

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

### **To ask for help or complain**

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Maureen Miller, practice manager and privacy officer  
1530 N 115<sup>th</sup> ST #305  
Seattle, WA 98133  
206 362-2464 x 2

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our Practice Manager/Privacy Officer at Northwest Physiatry Associates. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

## **Other disclosures and uses of protected health information**

### **Notification of family and others**

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

**Some of the ways that we may use and disclose your protected health information without your authorization are as follows:**

- With medical researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To funeral directors/coroners consistent with applicable law to allow them to carry out their duties.
- To organ procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To comply with workers' compensation laws—if you make a workers' compensation claim.
- For public health and safety purposes as allowed or required by law:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
- To report suspected abuse or neglect to public authorities.
- To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For health and safety oversight activities for example, we may share health information with the Department of Health.
- For disaster relief purposes for example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

- For work-related conditions that could affect employee health for example, an employer may ask us to assess health risks on a job site.
- To the military authorities of U.S. and foreign military personnel for example, the law may require us to provide information necessary to a military mission.
- In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- For specialized government functions for example, we may share information for national security purposes.

**Other uses and disclosures of protected health information**

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

**Web site**

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: *www.nwphysiatry.com*

**Effective date**

September 7, 2010