1. Name _____
   Last First MI
2. Birth Date _____
3. PCP _____
4. Referring Physician _____
5. Employment:
   - o Full time
   - o Part time
   - o Retired
   - o Occupation:_____
   - o Student
   - o Unemployed

YOUR MEDICAL HISTORY

- o Broken bones / fractures
- o Diabetes Type I__ Type II __
- o Heart disorder
- o Lung disorder
- o Muscular dystrophy
- o Epilepsy / Seizures
- o Kidney difficulties
- o High blood pressure
- o Low blood sugar
- o Infectious diseases
- o Parkinson's disease
- o Multiple Sclerosis
- o Other _____
- o Arthritis
- o Osteoporosis
- o Cancer
- o Allergies
- o Asthma
- o Depression
- o Vascular issues
- o Thyroid
- o Skin diseases
- o Blood disorders

SURGICAL HISTORY

List Surgeries and Dates

a. _____
b. _____
c. _____
d. _____
e. _____

MEDICATIONS

1. Please list all current medications you are taking? (including non-prescription drugs)

_____
_____
_____
_____
_____

CURRENT/GENERAL HEALTH

1. Overall perceived health
   - o Excellent
   - o Good
   - o Fair
   - o Poor

2. How often do you exercise?
   - o 5 times a week or more
   - o 3 times a week or less __
   - o 3-4 times a week
   - o Rarely

3. Do you smoke?
   - o Yes
   - o No

4. Alcohol

Days per week you drink:_____
How many drinks per day:_____

CURRENT / CHIEF COMPLAINT

1. Why are you seeking therapy intervention? _____
   _____
   _____
2. Date when injury began: _____
3. How were you injured? _____
   _____
   _____
4. Have you had a similar problem in the past?
   - o Yes
   - o No
5. Activities you are unable to do now due to pain or injury? _____
   _____
6. Pain level: (none=0 / worst=10) _____
7. Aggravating factors to pain?
   _____
   _____
8. Easing factors (to decrease pain)? _____
   _____
   _____
9. Next scheduled doctor recheck appointment?
   _____
10. Treatment for current condition? _____
    _____
    _____
11. List X-rays, MRI, Bone Scans etc. _____
    _____
    _____
12. Pertinent accidents or injuries and dates: _____
    _____
    _____

13. Personal goals for therapy: _____

_____

14. Any special needs you require? (be specific) _____

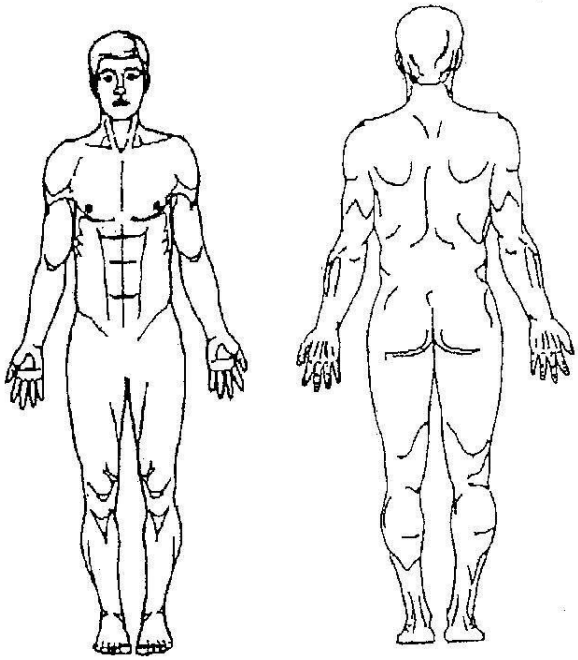
15. Other health care providers involved with your current condition?

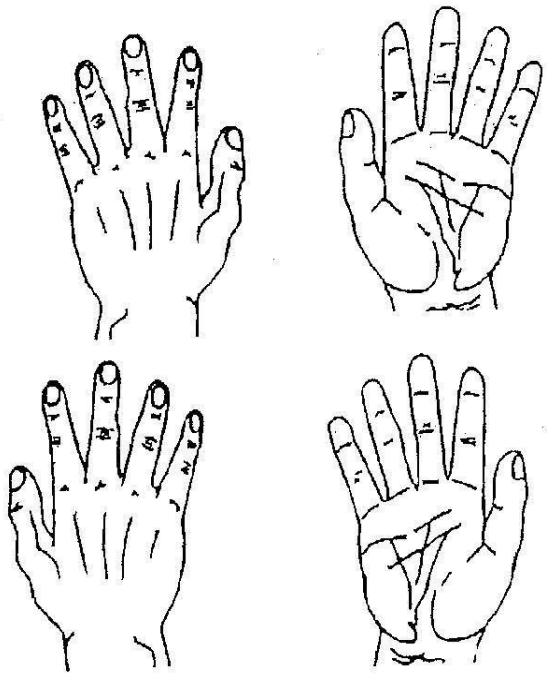
o Family Practitioner	o Massage Therapist	o Neurologist	o Rheumatologist

Please check the items that you have difficulty with or are unable to do at this time:

o Lifting groceries	o Opening jars	o Lifting a suitcase/briefcase
o Driving	o Food preparation	o Tying shoes
o Doing dishes	o Using a screwdriver/hammer	o Removing clothes from washer
o Grooming	o Sweeping/vacuuming	o Cutting with a knife
o Eating	o Zipping/buttoning	o Writing/typing
o Pouring from a pitcher	o Turning doorknobs	

16. Please mark on the appropriate chart below your area(s) of pain.





Applause Hand Therapy
2607 S. Southeast Blvd, Suite B150
Spokane, WA 99223

PATIENT REGISTRATION FORM

Referred by: Doctor / Self / Other
(please circle one)

PATIENT INFORMATION

Last Name _____ Gender _____ Marital Status _____
First Name _____ Initial _____ Referring Physician _____ Phone _____
Address _____ PCP _____ Phone _____
City, State, ZIP _____ Injured Area _____
Home Phone _____ Date of Injury _____
Work Phone _____ Related to: Work / Auto / Sports / Other
Cell Phone _____ Employer _____
Date of Birth _____ Age _____ Employer's Address _____
Social Security # _____ Occupation _____

RESPONSIBLE PARTY

Account # _____ Patient Relationship to Guarantor _____
Last Name _____ Gender _____ Marital Status _____
First Name _____ Initial _____ Date of Birth _____ Age _____
Address _____ Social Security # _____
City, State, ZIP _____ Home Phone _____
Employer _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber _____
Address _____ Policy ID # _____
City, State, ZIP _____ Group # _____
Telephone _____ Date of Birth _____
Effective Dates _____ Patient relationship to subscriber _____
Copay amount _____

Second Insurance _____ Subscriber _____
Address _____ Policy ID # _____
City, State, ZIP _____ Group # _____
Telephone _____ Date of Birth _____
Effective Dates _____ Patient relationship to subscriber _____
Copay amount _____

EMERGENCY CONTACT INFORMATION

Name _____ Home phone _____ Work _____
Relation to patient _____ Cell phone _____ Pager _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Applause Hand Therapy to release any medical information necessary to process insurance claims relating to the medical care rendered by Applause Hand Therapy.

_____ _____
Signature Date

ASSIGNMENT OF MEDICAL BENEFITS

I authorize payments of medical benefits to Applause Hand Therapy for any medical care rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature Date

HIPAA NOTICE

I acknowledge receipt of the HIPAA Notice of Privacy Practices for Applause Hand Therapy.

_____ _____
Signature Date

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Applause Hand Therapy for your therapy needs. This office is committed to providing the highest quality care. The following is an explanation of our office policy and agreement, which we ask you to read prior to any evaluation or treatment. All patients need to complete the information and medical history forms before seeing our therapists.

- Each patient is responsible for his or her own bill.
- Payment of all insurance co-payments and deductibles are required at the time service is rendered.
- Patients who have no insurance are required to pay 100% of services rendered each visit, unless other arrangements have been made. We accept cash, check, Visa, or MasterCard.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, it is the patient's responsibility to determine what the insurance company will allow for occupational therapy and obtain approval if necessary. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
- We do participate with most insurance companies; however, some plans require a referral from the primary care physician. A written referral and any required pre-authorization must be on file prior to each office visit. It will be your responsibility to contact your insurance carrier to confirm pre-authorization and to extend the number of visits approved.
- A $15.00 fee will be charged on all returned checks.
- Any responsibility balance older than 60 days is subject to an interest charge of 1% per month.

LATE CANCELLATIONS AND NO-SHOWS

Cancellations or changes must be made 24 hours in advance of the scheduled appointment. If a patient fails to show or cancels two scheduled appointments, treatment will be discontinued.

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item. We accept cash, check, Visa, or MasterCard.

PATIENT CONSENT AND RELEASE

I understand that Applause Hand Therapy is not responsible for any personal belongings that I bring into the clinic. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending L&I claims. I understand that the parent accompanying a minor for treatment will be responsible for payment. I authorize Applause Hand Therapy and its subsidiaries to release any necessary information requested by my insurance carrier and authorize payment directly to Applause Hand Therapy and its subsidiaries for any benefits available under my insurance plan. I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for Sexually Transmitted Diseases, AIDS or HIV Infection, Alcohol and/or Drug Abuse, or Mental Health Conditions.

I acknowledge that I have read and understand: the financial policy and agreement, the cancellation/no-show policy, the medical supplies and orthotics policy, and the patient consent and release as stated above.

_____ _____

Patient Signature Date
(If patient is a minor, parent or guardian's signature)

LIFETIME AUTHORIZATION FOR MEDICARE

I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me. I authorize the below named provider to release to the Social Security Administration, its intermediaries, or carriers and information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Provider's Name: Applause Hand Therapy
Provider's Address: 2607 S. Southeast Blvd. #B150
Spokane, WA 99223

Patient's Name: _____
HIC: _____
Patient's Address: _____
_____
_____

_____ _____

Patient's Signature Date

I acknowledge that I have read and understand: the Medicare authorization.

_____ _____

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

Applause Hand Therapy, PLLC

Effective Date September 1, 2013

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 Applause Hand Therapy, PLLC. Julie K Paull, OTR/L of our office at 509-532-8114 – 2607 S. Southeast Blvd. Ste. B150, Spokane, WA 99223.

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:

ü **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.

ü **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.

ü **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.

ü **Appointment Reminders.** We may contact you to remind you of your appointment.

ü **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may interest you.

ü **Health-Related Products and Services.** We may tell you about health-related products or services that may interest you.

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.

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:

ü **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.

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

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü **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.

ü 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.

ü **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:

ü **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 Julie K Paull, OTR/L 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.

ü **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 Julie K Paull, OTR/L. 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:

ü We did not create, unless the person or entity that created the information is no longer available to make the correction

ü Is not part of the health information that we keep

ü You would not be permitted to inspect and copy

ü Is accurate and complete

ü **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 [*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.

ü **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 Julie K. Paull, OTR/L. We will provide you with one of these forms at your request.

ü **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 Julie K. Paull, OTR/L. 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.

ü **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 Julie K. Paull, OTR/L, Applause Hand Therapy, PLLC.

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 [*insert the name, title, and phone number of the contact person or office responsible for handling complaints listed on the first page as the contact for more information about this notice.].* ***You will not be penalized for filing a complaint.***