NW Physiatry Associates

Evan M. Cantini, MD
Jeffery E. Fitzthum, DC, MD, MPH
Alexandr I. Chatilo, MD

1530 N 115th St, Suite 305 • Seattle, WA 98133
206 362-2464, phone 206 362-2141, fax

Specialists in electrodiagnosis and rehabilitation medicine

To: All Patients
From: Maureen Miller, clinic 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: ____

9/24/07 mgr/clinic&pt.responsibilities notice

Patient Registration

SSN: ________________ Home Tel#:________________________ Ext:____________

Last Name:_____________________________________ Work Tel#:________________________ Ext:____________

First Name:________________________ MI:______ Cell#:__________________________

Address 1:______________________________________ ☐ male ☐ female

Address 2:______________________________________ Date of Birth:_________________________

City:_____________________________ State:______ Employer:____

Zip code:_______________

Here to see Dr: ☐ Cantini ☐ Fitzthum ☐ Chatilo

I am: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Referring Dr:_________________________________

Work: ☐ full-time ☐ part-time ☐ self employed ☐ not employed ☐ military duty ☐ retired

Primary Care Provider: _________________________

Primary language: _____________________________

I am: ☐ hard of hearing ☐ need assistance from the curb

Who is the subscriber on your insurance policy: ☐ self ☐ spouse ☐ parent

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:________

Please list an emergency contact: Relationship to you: ☐ Spouse ☐ Parent ☐ Son/Daughter ☐ Other relative ☐ Friend

Home Tel#:________________________ Ext:____________

Last Name:_____________________________________ Work Tel#:________________________ Ext:____________

First Name:________________________ MI:______ Cell#:__________________________

Address 1:______________________________________ ☐ male ☐ female

Address 2:______________________________________ City:____________________________ State: ______ Zip:________

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#:____________________________________ Ext:______ Secondary insurance: ☐ yes ☐ no

Secondary insurance carrier:____

Policy #:____ Patient's Policy # suffix:________________________

Group name/number:______________________________ Subscriber's Policy # suffix:_____________________

Policy Tel#:_____________________________________ Ext:______ Third insurance: ☐ yes ☐ no

Tertiary (third) insurance carrier:____

Policy #:____ Patient's Policy # suffix:________________________

Group name/number:______________________________ Subscriber's Policy # suffix:_____________________

Policy Tel#:_____________________________________ Ext:______

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 Physiatry 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

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Financial Policies

Patient Name (please print) : ______________________________

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, then bill you for the balance due (unpaid charges allowed by our contract with the insurance carrier). We expect payment within thirty days on this balance due. There is a $25 self-pay charge assessed for completing forms not paid by insurance and for failing to provide at least 48 hours notice when you cannot keep an appointment.

We require all patients to release payment for services rendered to be paid by your insurance directly to Northwest Physiatry Associates.

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.

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 the month following receipt of payment from your insurance 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; if there is no other insurance we will place you on the self-pay plan.

Self Pay: Self pay patients are required to make a large payment in advance towards services rendered. 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:__________________________

SYMPTOMS: Please mark (X) in the available blanks if any of the following apply to you NOW or in the PAST

Now	Past	HEAD, EYES, EARS, NOSE, THROAT
❑	❑	Dizziness
❑	❑	Severe Headaches
❑	❑	Double Vision
❑	❑	Poor Eyesight
❑	❑	Ear or Hearing Trouble
❑	❑	Frequent Nose Trouble
❑	❑	Persistent Hoarseness
❑	❑	Teeth Trouble
❑	❑	Sore Mouth

Now	Past	LUNGS
❑	❑	Daily Cough
❑	❑	Daily Coughing of Phlegm
❑	❑	Coughing Blood
❑	❑	Persistent Wheezing
❑	❑	Shortness Of Breath
❑	❑	Chest Pain When Breathing

Now	Past	HEART CIRCULATION
❑	❑	Chest Pain When Walking
❑	❑	Heart Palpitation
❑	❑	Leg Vein Trouble
❑	❑	Leg Pain When Walking
❑	❑	Ankle Swelling

Now	Past	STOMACH, INTESTINAL
❑	❑	Trouble Swallowing
❑	❑	Frequent or Severe Nausea
❑	❑	Frequent or Severe Heartburn
❑	❑	Frequent indigestion
❑	❑	Frequent or Severe Stomach pain
❑	❑	Frequent or Severe Vomiting
❑	❑	Vomiting Blood
❑	❑	Yellow Jaundice
❑	❑	Prolonged or Frequent Diarrhea
❑	❑	Constipation
❑	❑	Blood in bowel Movements
❑	❑	Hemorrhoids (Piles)

Now	Past	URINARY
❑	❑	Frequent Urination
❑	❑	Painful Urination
❑	❑	Blood Urine
❑	❑	Trouble Starting Urine
❑	❑	Urinate more than 2 times a night
❑	❑	Trouble holding Urine

Now	Past	NERVOUS SYSTEM
❑	❑	Frequent Loss Of Balance
❑	❑	Fainting Spells (black outs)
❑	❑	Convulsions (seizures, fits, epilepsy)
❑	❑	Tremor (shaking, tumbling)
❑	❑	Paralysis
❑	❑	Numbness (body parts "go to sleep)
❑	❑	Nervousness
❑	❑	Excessive worry
❑	❑	Trouble Sleeping
❑	❑	Memory Trouble
❑	❑	Trouble Concentrating
❑	❑	Depression (feeling blue)
❑	❑	Crying Spells
❑	❑	Feelings Of Worthlessness
❑	❑	Trouble getting along with people

Now	Past	BONES. JOINTS. MUSCLES
❑	❑	Joint Pains and Swelling
❑	❑	Severe Lack of Strength

Now	Past	MALES
❑	❑	Discharge From Penis
❑	❑	Testicles Trouble
❑	❑	Sexual Trouble

Now	Past	FEMALES
❑	❑	Breast Lumps or Discharge
❑	❑	Unusual Bleeding from Vagina
❑	❑	Unusual Discharge from Vagina
❑	❑	Sexual Trouble
❑	❑	Date Last Pap Smear __________

Now	Past	GENERAL
❑	❑	Unexplained Weight Loss or Gain
❑	❑	Unexplained Fever
❑	❑	Night Sweats
❑	❑	Can't Stand hot weather
❑	❑	Can't Stand cold weather
❑	❑	Persistent Skin Rash or Itching

HABITS

Smoking: Cigarettes ❑ Pipe ❑ Cigar ❑ None

#Years Daily Amount. _______

Alcohol: ❑ Beer ❑ Wine ❑ Hard liquors ❑ None

Amount per week_______

Hours-of Sleep per Night ______ *#Meals/Day______*

Name: ___________________________________

☐ Male ☐ Female Age: __________

Date of Birth_________ Today's Date________

Occupation________________________________

<u>Medicines:</u> Are you allergic to or have had a bad reaction to any medicine or any other substances?

☐ Yes ☐ No

If yes please list the medicine(s)/substance(s)

____
____
____
____
____
____

What prescription drugs are you currently taking?
(Please list dose and frequency)

____
____
____
____
____
____

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

If yes please list the medicine(s)/substance(s)

____
____
____
____
____

Hospitalizations: Please list all of your hospitalizations.

<u>Operation</u>	<u>Place</u>	<u>Year</u>

What would you like to discuss with the Doctor today?

____
____
____
____
____

YOUR HEALTH HISTORY

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

- ☐ Asthma
- ☐ Cancer
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Liver Disease, Jaundice, Hepatitis
- ☐ Mental Problem/Nervous breakdown
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Serious Injury or Accident
- ☐ Sugar Diabetes
- ☐ Thyroid Gland Trouble
- ☐ Tuberculosis (TB)
- ☐ Uncontrolled Bleeding
- ☐ Venereal Disease (VD)
- ☐ AIDS (HIV)

FAMILY HEALTH HISTORY

	DOB	**Present Health**	**Cause of Death**
Mother	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Father	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Bro/Sis	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Bro/Sis	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Bro/Sis	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Bro/Sis	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Bro/Sis	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Child	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Child	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Child	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________
Child	______	☐ Good ☐ Fair ☐ Poor ☐ Deceased	__________

NORTHWEST PHYSIATRY ASSOCIATES

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice

- Any health care professional authorized to enter information in your medical record at Northwest Physiatry Associates (NWPA).
- All employees, staff and other authorized personnel.
- This notice is also a joint notice of privacy practices by NWPA and other non-employee physicians who have agreed to follow this notice in connection with care provided at NWPA. We may share your health information with these independent physicians for treatment, payment and health care operations activities related to care provided at NWPA.

Our Responsibilities

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

The law protects the privacy of the health information we create and obtain in providing 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 laws allow us to use and disclose your protected health information for purposes of treatment, payment, and health care operations.

How We May Use and Disclose Medical Information About You

For Treatment. Information obtained by a physician or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you. For example, your physician may need to consult with specialists about your care. Information about you would be shared with them to help understand your care needs.

For Payment. We request payment from your health plan or other payers. They need information from us about your medical care such as diagnosis, procedures performed, or recommended care. For example, we may need to give your health plan information about a procedure you received so your health plan will pay us or reimburse you for the procedure.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example,

- We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- We may disclose information to physicians, nurses, technicians, and other personnel for review and learning purposes.
- We may also call you by name in the waiting room when your physician is ready to see you.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review;
    - Accounting, legal, risk management and insurance services;
    - Audit functions, including fraud and abuse detection and compliance programs.

Other Uses and Disclosures

Communication with Family and Friends. We may release medical information about you to a family member or friend who is involved in your care and/or helps pay for your care. We may 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.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at NWPA. If we are unable to make contact with you, we may leave a message on your home phone, your cell phone or with a family member. ***If you wish to restrict messaging please contact our privacy officer.***

Treatment Alternatives. We may contact you to tell you about or recommend possible treatment options or alternatives that may be of interest to you. If we are unable to make contact with you, we may leave a message on your home phone, your cell phone or with a family member. ***If you wish to restrict messaging please contact our privacy officer.***

Health-Related Benefits and Services. We may contact you to tell you about health related benefits, services, or health care education classes that may be of interest to you. If we are unable to make contact with you, we may leave a message on your home phone, your cell phone or with a family member. ***If you wish to restrict messaging please contact our privacy officer.***

Research. We may disclose information to researchers when an institutional review board has approved the research proposal and established protocols to ensure the privacy of your health information. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are.

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

To Avert a Serious Threat to Health or Safety. We may use and disclose medical 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. Any disclosure, however, would only be to someone able to prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health. As required by law, we may disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. 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 medical information about you 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.

Law Enforcement. We may release medical information if asked to do so by law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the clinic;

- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the clinic to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official necessary for your health and the health and safety of other individuals.

Your Health Information Rights

Right to this Notice: You have a right to a paper copy of this notice. You may ask us to give you a copy at any time.

Right to Inspect and Copy: You have a right to inspect and receive a copy of certain health care information including certain medical and billing records. You must submit your request in writing to Northwest Physiatry Associates at: 1530 N. 115th Street Suite 305, Seattle, WA 98133 (206-362-2464). If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical record, you may request that the denial be reviewed. We will comply with the outcome of the review.

Right to Request Amendment: You have a right to ask that your health information be amended by giving a written request to Northwest Physiatry Associates at: 1530 N. 115th Street Suite 305, Seattle, WA 98133 (206-362-2464). We have the right to deny this request under certain circumstances. You may write a statement of disagreement if your request is denied. This statement of disagreement will be stored in your medical record, and included with any release of your records.

Right to a List of Disclosures. You have the right to request a list of disclosures. This is a record of certain disclosures we made of medical information about you in accordance with law.

You must submit your request in writing to Northwest Physiatry Associates at: 1530 N. 115th Street Suite 305, Seattle, WA 98133 (206-362-2464). The first time you request a list within a 12 month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost

involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restriction: You have a right to ask us to restrict certain uses and disclosures of your health information. You may be asked to make this request in writing. Ask your caregiver if you have questions about this. We will comply with all reasonable requests.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a specific way or location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may be asked to make your request in writing. Ask the person that gave you this notice for more information about this process. We will comply with all reasonable requests. Your request must specify how or where you wish to be contacted.

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.

Complaints

If you believe your privacy rights have been violated, you may contact the NWPA Privacy Officer at (206) 362-2464 or submit your complaint in writing to the Privacy Officer at: NWPA, 1530 N. 115th Street Suite 305, Seattle, WA 98133. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

Other uses and disclosures of your health 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 with permission to use or disclose health information about you under these circumstances, 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.

If you have any questions about this notice please contact the Privacy Officer at (206) 362-2464.

Effective: April 14, 2003
Revised: March 5, 2008