ELECTRODIAGNOSIS & MUSCULOSKELETAL ASSOCIATES OF PUGET SOUND, P.S.

PATIENT REGISTRATION

ALL PERTINENT INFORMATION MUST BE COMPLETED

LAST NAME_____ FIRST NAME _____ MI _____

MAILING ADDRESS _____ APT# _____ CITY _____

STATE _____ ZIP CODE _____ PHONE _____ CELL _____

SSN _____ DOB _____ GENDER _____ MARITAL STATUS _____

EMAIL _____

REFERRING DOCTOR _____ PHONE _____

EMPLOYER _____ MAY WE CONTACT YOU AT WORK? YES _____ NO _____

PRIMARY INSURANCE PROVIDER _____

ADDRESS_____

PHONE# _____ ID# _____ GROUP# _____

SUBSCRIBER NAME _____ DOB _____ RELATIONSHIP _____

SECONDARY INSURANCE PROVIDER _____

ADDRESS_____

PHONE# _____ ID# _____ GROUP# _____

SUBSCRIBER NAME _____ DOB _____ RELATIONSHIP _____

IS THIS JOB RELATED? _____ CLAIM# _____ BODY PART _____

NAME OF SELF-INSURED _____ PHONE _____

ADDRESS_____

EMPLOYER AT **TIME OF INJURY** _____ PHONE _____

IS THIS CLAIM OPEN? YES _____ NO _____ DATE OF INJURY _____

IS THIS A RESULT OF AN AUTO ACCIDENT _____ DATE OF INJURY _____ STATE ACCIDENT OCCURRED ____

ADJUSTER'S NAME _____ PHONE _____

INSURANCE COMPANY _____ CLAIM # _____

INSURANCE ADDRESS _____ PHONE _____

ATTORNEY _____ PHONE _____

PLEASE NOTE, ELECTRODIAGNOSIS & MUSCULOSKELETAL ASSOCIATES OF PUGET SOUND, P.S. DOES NOT ACCEPT LIENS

EMERGENCY CONTACT _____**PHONE** _____ **RELATIONSHIP** _____

In order to meet certain government standards and to provide the best care possible, Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S. is required to record specific demographic information about our patients, including new fields of race and ethnicity. This information is required by CMS for Meaningful Use in the interest of implementing technology that is patient-centered, evidence-based, and prevention-oriented.

Please choose from the selections listed below from the Race and Ethnicity categories:

Ethnicity relates to cultural factors such as nationality, culture, ancestry, language and beliefs.

- Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race.

Ethnicity – Please choose only one

- ☐ Hispanic
- ☐ Non-Hispanic or Non-Latino
- ☐ Unknown
- ☐ Prefer not to state

Race refers to a person's physical appearance, such as skin color, eye color, hair color, etc.

- ☐ **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Black or African American** – A person having origins in any of the black racial groups of Africa.

Race – Please select all that apply and indicate the primary selection.

- ☐ American Indian / Alaskan
- ☐ Native Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Other
- ☐ Unknown
- ☐ Prefer not to state

I CERTIFY THAT THE INFORMATION I IHAVE GIVEN ABOVE IS TRUE AND CORRECT.

Patient/Parent or other authorized representative signature _____

Date: _____

ELECTRODIAGNOSIS & MUSCULOSKELETAL ASSOCIATES
OF PUGET SOUND

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WWW.EMAPUGETSOUND.COM

FINANCIAL POLICY

Thank you for choosing us to provide your medical care in the field of ELECTRODIAGNOSTIC, MUSCULOSKELETAL AND PHYSICAL MEDICINE. The following is a statement of our financial policy, which we require that you read, agree to and sign prior to any treatment.

It is the policy of our office to bill all insurance claims to your insurance company as a service to you. We expect our patients to provide us with up-to-date, accurate insurance information to ensure quick and efficient claims processing. Co-payments should be made at the time of service.

If your insurance requires a referral, it is you or your primary care doctor's responsibility to make sure that we have it at the time of service. Your failure to do so will result in the charges being your full responsibility.

The responsibility for payment of your account remains with you at all times including closed or rejected Labor and Industries claims or auto accident claims. We do NOT bill third party insurance companies.

Your insurance policy is a contract between you and the insurance company. In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of the bill. If your claim is denied, you are responsible for the entire charge.

If no insurance is available, payment is expected at the time of service. For your convenience we accept personal checks, credit card or cash. If your account is sent to collections for lack of payment, you will be terminated from the practice.

NEW PATIENTS: If no insurance is available, a $100.00 payment (either cash or credit card) is expected to be received at our office at least TWO days prior to the appointment. This amount will be forfeited if the appointment is cancelled or rescheduled. ESTABLISHED PATIENTS: If no insurance is available, payment is expected at the time of service. For your convenience we accept personal checks, credit card or cash.

This office takes assignment on Medicare patients as well as the individual contracted insurance companies.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR ON THE ACCOUNT OF _____. I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO ELECTRODIAGNOSIS & MUSCULOSKELETAL ASSOCIATES OF PUGET SOUND, P.S. FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

I also authorize EMAPs to discuss my financial information/billing information, on my behalf with

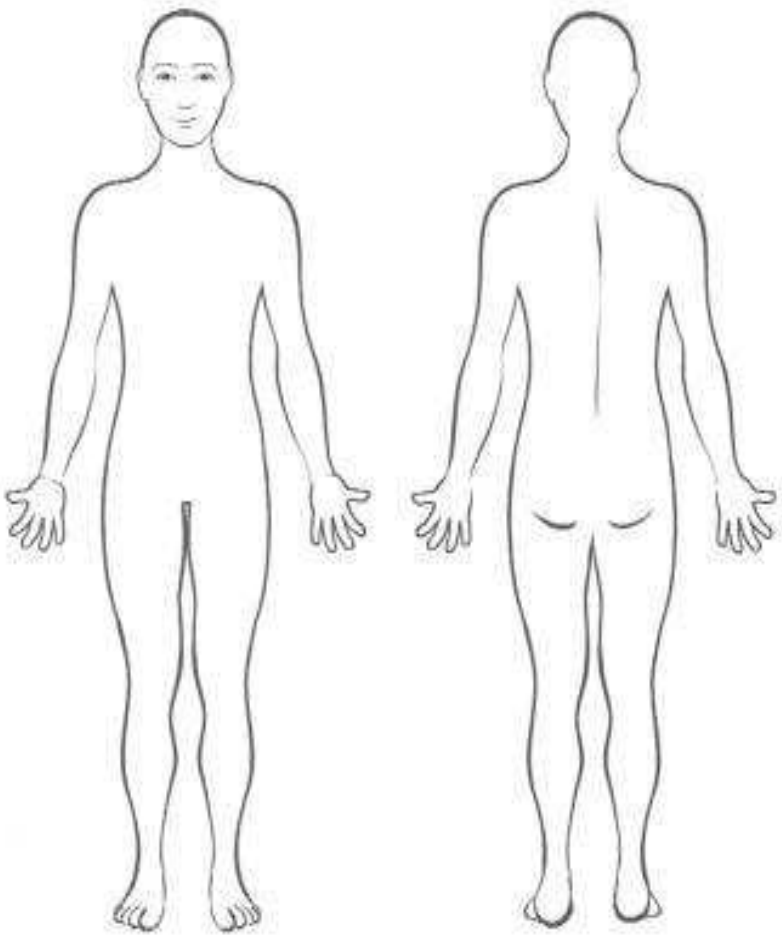
_____.

SIGNATURE_____ DATE _____

PAIN INFORMATION SHEET

PLEASE MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE SENSATIONS DESCRIBED BELOW.
PLEASE USE THE APPROPRIATE SYMBOL & INCLUDE ALL AREAS.

	****		====		OOOO		XXXX		////
ACHE	****	**NUMBNESS**	====	**PINS & NEEDLES**	OOOO	**BURNING**	XXXX	**STABBING**	////
	****		====		OOOO		XXXX		////



R **L** **L** **R**

WHEN DID THE PAIN START? _____

NAME _____

DATE _____

Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S.
Main Office – 3315 S. 23rd Street, Suite #200
Tacoma, WA 98405

PERSONAL HEALTH HISTORY

Name: _____ Date of Birth: ____ Age: ___ Sex: __ [Claim # (if any) _____ DOI: _____]

SS#: _____ Height: _____ Weight: _____ Right handed _____ or Left _____

List your major health problems. If an accident or injury, list in descending order of priority and the duration of the symptoms (Indicate body site involved):

1. _____
2. _____
3. _____
4. _____
5. _____

Describe the situation & date leading to your problem or injury: _____
_____
_____

What symptoms did you experience at the time of onset, and the days following? _____
_____
_____

When did you first seek medical care, for what and with whom? _____
_____
_____

Please detail below all treatments relating to your problem(s), or injury, from onset until now.
Include providers: ***M.D./D.O.s, Chiropractic, Physical Therapist, Massage, Acupuncture, etc.***
Include tests: ***X-Rays, CT &/or MRI scans, EMGs, Bone Scans & Labs***
Include therapies: ***Heat, Ice, Exercises, Massage; Cortisone injections – spine, ligaments or joints; Surgeries***

Provider / Location	Dates	Therapy & Tests	Treatment or Surgery	Better/worse/same
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CURRENT STATUS

What is your major concern now?
_____
_____

If pain, where is it located? _____ Describe what it feels like: _____
What makes it worse?
What makes it better?
How much of the time do you have pain in a day?
_____ Constant _____ Nearly constant (50%-80%) _____ Intermittent (25%-49%) _____ Occasional (0%-25%)
Please circle your level of <u>pain</u> or <u>discomfort</u> on the scale below from 0 (no pain) to 10 (most severe pain):
At best: 0 1 2 3 4 5 6 7 8 9 10 At worst: 0 1 2 3 4 5 6 7 8 9 10
Please circle the appropriate numbers reflecting your <u>emotional</u> status:
Anxiety - 0 1 2 3 4 5 6 7 8 9 10 if significant, describe: _____
Irritability – 0 1 2 3 4 5 6 7 8 9 10 _____
Depression – 0 1 2 3 4 5 6 7 8 9 10 _____

FUNCTIONAL STATUS

Briefly describe your typical daily routine: _____
_____
_____
List activities of daily living that you have difficulty performing: _____
List hobbies / sports / activities that you have difficulty participating in: _____
How long can you sit comfortably at one time? _____ hours if limitations, describe _____
How long can you stand comfortably at one time? _____ hours _____
How far can you walk comfortably at one time? _____ miles _____
How much can you lift & carry comfortably _____ pounds … lift & carry maximally? ____ pounds

LIFESTYLE HISTORY

Do you drink coffee or caffeinated drinks? Circle one: Yes / No If yes, # cups or cans/day _____
Are you a cigarette smoker now or in past? Circle one: Yes / No If yes, Current smoker? Yes / No
If quit, quitting date _____ If ever a smoker, # cigarettes/day _____ # years smoked _____
Do you consume alcohol now or in past? Circle one: Yes / No If yes, still drinking now? Yes / No
If current or past drinking, # of drinks *per week* (1 drink = 12 oz beer, 5 oz wine, 1.5 oz liquor)
0-2 _____ 3-7 _____ 8-15 _____ more than 15+_____ # years of alcohol usage _____
Have you ever been told that you have an alcohol or drug problem/addiction? Circle one: Yes / No
If Yes, have you been in alcohol or drug treatment? Yes / No If yes, date(s): _____
Clarify: Alcohol &/or what drugs? _____
Have you ever: Felt you should cut down or felt badly about your drinking or drug use? Yes / No
Felt criticized for your drinking or drug use? Yes / No
Had an early morning drink to steady nerves or get rid of a hangover? Yes / No
Had a DWI citation? Yes / No
Used alcohol &/or drugs more than prescribed to control pain? Yes / No
Used illicit street drugs to control pain, or for recreational use? Yes / No
If yes to any of the above, please describe _____
_____
_____

SOCIAL/FAMILY HISTORY

Birthplace: _____ Where did you grow up? _____ # years in this area? _____
Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
 # times Married _____
# of Children: _____ # of people in household: _____ Explain _____
Any major diseases in family?: Father's side (list) _____
Mother's side _____
Siblings _____
Living situation: House _____ Apartment _____ Family/Friends _____ Shelter _____ Other _____
Educational level: _____ Employed: Yes / No If not, disabled? Yes / No Retired? Yes / No
Please describe the work that you do (if applicable) _____
Have you been in the Military? Yes / No If yes, branch _____
Do you have a Service-Connected Disability? Yes / No If yes, % & for what _____

CLAIM RELATED OCCUPATIONAL HISTORY

***If applicable,* Employer at injury: _____ Job title? _____ Hours worked/week? _____**
Briefly describe your regular job activities: (include lifting requirements) _____
_____Is modified
work available to fit your restrictions? Yes / No Clarify if needed _____
Current work: Regular duty _____ Light Duty _____ Medical Leave _____ Time Loss _____
Do you have an assigned vocational counselor? Yes / No Clarify _____
If not working with intentions of returning to work, list all active return to work plans (be specific): _____
_____
_____
Do you have an attorney assisting your case? Yes / No If yes, explain _____

PAST MEDICAL/SURGICAL HISTORY

Do you have major health / medical problems nor or in the past? If yes, please list below:

1_____ **2**_____ **3**_____
4_____ **5**_____ **6**_____

List names of health providers & specialists who are treating you now or in the recent past:

1_____ **2**_____ **3**_____
4_____ **5**_____ **6**_____

List all surgeries (not already mentioned, to include day surgeries):

Hospital/Surgery Center	Dates	Illness	Surgery/Procedure

List any prior hospital admissions other than for surgery

Hospital	Dates	Illness or Illnesses

List any prior work, or motor vehicle or other significant injuries; and if so, detail including residuals:

Injury or Injuries	Dates off Work	Claim	Treatment & Residuals
	_____ to _____		
	_____ _____		
	_____ _____		

List any significant prior joint, ligament, muscle or bone sports/recreational injuries from your past:

_____ _____ _____ _____ _____

Do you have, or have you ever had, any of the following? If <u>Yes</u>, please <u>Check</u>, otherwise leave blank:

Anxiety problems	_____	**Depression**	_____
Arthritis	_____	**Asthma**	_____
Fractures	_____	**Tendonitis/Fasciitis**	_____
Bronchitis/COPD/Emphysema	_____	**Cancer**	_____
Diabetes	_____	**Head Injury**	_____
Heart Problems	_____	**Hypertension**	_____
Headaches	_____	**Neck or Back Injury**	_____
Liver problems	_____	**Hepatitis 'B' or 'C'**	_____
Kidney problems	_____	**Hernias**	_____
Reflux disease or Stomach Ulcers	_____	**Excessive Thirst**	_____
Stroke	_____	**Pinched nerves**	_____
Fibromyalgia/Chronic Fatigue	_____	**Colitis or GI bleeding**	_____
Thyroid problems	_____	**AIDS/HIV or high risk**	_____

If yes to the above, please specify any treatment _____
_____

MEDICATION HISTORY

List all medications including dosages that you are currently using regularly.
Include medications for <u>ALL</u> health problems, both prescription, non-prescription, & supplements:

Name	Dose	Current Use Pattern (# times/day)	Feel better / worse / same

List prior Medications tried, particularly those prescribed for your current problem(s):

Name	Dose	Prior use pattern (#tab/day)	List side effects if any
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List medications and foods that cause you <u>side effects</u> or <u>allergic</u> reactions:

Name	Reaction
_____	_____
_____	_____

Have you ever had a reaction to anesthetic, iodine or contrast agents? <u>Yes</u> / <u>No

If <u>Yes</u>, please specify type and severity of the reaction _____

REVIEW OF SYSTEMS

	Past	Now		Past	Now
Bleeding Gums	_____	_____	**Frequent Cough**	_____	_____
Swallowing problems	_____	_____	**Wheezing**	_____	_____
Change of Voice	_____	_____	**Shortness of Breath**	_____	_____
Lumps in the Neck	_____	_____	**Coughing blood**	_____	_____
Double / Blurred vision	_____	_____	**Dizziness**	_____	_____
Hearing difficulty	_____	_____	**Irregular heart rate**	_____	_____
Sinus trouble	_____	_____	**Heart murmur**	_____	_____
Heartburn	_____	_____	**Chest pain/tightness**	_____	_____
Nausea / vomiting	_____	_____	**Frequent loose stools**	_____	_____
Frequent urination	_____	_____	**Burning urination**	_____	_____
Urinary leakage	_____	_____	**Blood in urine**	_____	_____
Inability to urinate	_____	_____	**Black/Bloody stools**	_____	_____
Severe constipation	_____	_____	**Burning pain in arms/legs**	_____	_____
Altered sensations	_____	_____	**Weakness in arms/legs**	_____	_____
Difficult falling asleep	_____	_____	**Awaken frequently**	_____	_____
Aching or stiff joints	_____	_____	**Swollen joints**	_____	_____
Socially isolated	_____	_____	**Frequent crying**	_____	_____
Feelings of hopelessness	_____	_____	**Trouble remembering**	_____	_____
Inability to concentrate	_____	_____	**Suicidal thoughts**	_____	_____

Optional, helpful if relevant:

If age over 50, have you had: Colonoscopy <u>Yes</u> / <u>No

If yes, do you know the results? _____

<u>Females</u> only:

Irregular periods	_____	_____	**Premenstrual tension**	_____	_____
Pregnancy	_____	_____	**Menopausal**	_____	_____

Have you had: A Pap smear/pelvic exam within the last 2 years? <u>Yes</u> / <u>No

Mammography within the last 2 years? <u>Yes</u> / <u>No

Back pain increased with menstrual periods? <u>Yes</u> / <u>No

Could you be pregnant? <u>Yes</u> / <u>No

Clarify if necessary _____

<u>Males</u> only:

Impaired erections?

Have you had: A prostate exam within the last 2 years? <u>Yes</u> / <u>No

A PSA level (Prostate Specific Antigen)? <u>Yes</u> / <u>No

Clarify if necessary _____

_____ _____

PATIENT SIGNATURE **DATE**

Thank you for completing this form!

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TACOMA, WA 98405
TEL 253-272-9994 FAX 253-572-0468
WWW.EMAPUGETSOUND.COM

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth:_____SSN:_____

Previous Name: _____

I request and authorize _____
to release health care information of the patient named above..

To:_____

Address:_____

City, State:_____Zip:_____

Purpose for which this health care information is being disclosed:
Physician Insurance Attorney Personal

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:
_____

_____ All healthcare information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders / mental health, drug and/or alcohol use. You are specifically authorized to release all health care information relating to my diagnosis, testing or treatment.

Signature:_____Date: _____

Relationship:_____
(Self, Parent, Legal Guardian, Personal Representative)

THIS AUTHORIZATION EXPIRES 90 DAYS FROM DATE SIGNED

Please be advised that a third party company copies our medical records, and there may be a charge associated with your records request from them. ***Please contact Health Port at (800)-367-1500****.*

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ACKNOWLEDGMENT OF RECEIPT / OFFER OF NOTICE OF PRIVACY PRACTICES

Dear Patient:

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

You have the right to review our notice before signing this acknowledgement, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

We appreciate you signing this form, which acknowledges that you have received or have been offered and/or refused a copy of our Notice.

Patient Name _____

Patient / Representative Signature _____

Date_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program, which requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared the 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, payment, and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews.
- Health care operations includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-classified health information by removing all references to individually identifiable information.

We may also 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 disclosers 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 action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by preparing a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. 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 a copy of 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 obtain a paper copy of the notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you notice of our legal duties and privacy practices with respect to protected health information.

The Notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. This will be posted in our office and you may also request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy has been violated. You have the right to file a formal written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of the notice or the practice and procedures of our office. We will not retaliate against you for filing a complaint.

This Notice is a brief description of our privacy practices. For the complete notice please request a copy from the receptionist.

For more information about HIPAA or to file a complaint: Office for Civil Rights
U.S. Department of Health and Human Services
701 Fifth Avenue, Suite 1600, MS - 11
Seattle, WA 98104
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S.

Amendment to Amended HIPAA Privacy and Security Policies and Procedures Effective September 1, 2013

I. PURPOSES AND APPLICATION.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Washington law, in each case as amended, and in accordance with professional ethics Electrodiagnosis & Musculoskeletal Associates of Puget Sound protects the privacy and security of our patients' health care information. This includes all information in our possession relating to a patient's health care, in whatever form, which identifies or could be used to identify the patient (referred to herein as "PHI").

This Amendment to HIPAA Privacy and Security Policies and Procedures ("Policies and Procedures") is intended to describe the amendments to the Practice's privacy and security practices which protect our patients' health care information. The Practice's privacy practices are described in detail in its Notice of Privacy Practices. In interpreting these Policies and Procedures, the Notice shall be referred to as the Practice's statement of when and under what conditions it will use and disclose a patient's health care information.

The Policies and Procedures, as amended hereby, apply to all of the Practice's activities and personnel, including all professional, management and administrative staff as of the Effective Date.

II. AMENDMENTS.

The policies and Procedures are hereby amended by substitution of the following provisions in place of any comparable provisions contained in the Policies and Procedures:

A. Patient Right to Review and Copy.

1. Policy. Except in certain limited situations in which access may or must be restricted pursuant to law, a patient and/or the patient's personal representative has a right to inspect and obtain a copy of the patient's medical record.

2. Procedures.

- Any request to inspect or copy a medical record must be in writing, identify the patient, state the name and address of the person to whom the record is being sent, state the information requested and identify the person making the request.

- If requested, the medical record maintained by the Practice in an electronic format shall be provided in the format requested (if readily producible in such format) or another agreed-upon electronic format.

- In determining whether a request covers information to which patient does not have access, refer to 45 CFR 164.524.

- Within 15 working days of the request, the request shall be granted or denied, or, if there is a delay due to unusual circumstances, the reason for the delay and a date for access shall be given.

- The access shall be granted under conditions reasonably necessary to protect the medical record.

- If access is denied, the denial shall be made in writing, stating the reason for the denial and advising the requesting party of any right of review.

- Requests for access, approvals and denials, and final determinations shall be kept or noted in the patient's medical record.

- Copies of requested records shall be made by a third party, HealthPort, and charged to the requester at the rate of per page authorized by the Washington Department of Health.

B. Right to Restrict Uses and Disclosures.

1. **Policy.** A patient may request that the Practice restrict uses of PHI where the disclosure is for purposes of carrying out payment or healthcare operations (including fundraising), except disclosures permitted or required by law or disclosures to a person or entity who has paid the charges for the services in full.
2. **Procedures.**

    - A patient's request for restriction on the use or disclosure of PHI must be made in writing or noted in the medical record.

    - A patient may terminate or modify restrictions, provided the termination or modification must be in writing.

    - A denial of any request, and the termination of any restriction, shall be in writing or noted in the medical record.

    - Determination regarding any request shall be by the health care provider currently treating the patient, or, if not available, by a provider designated by the Privacy Officer.

C. Patient's Right to be Notified of Breach.

1. **Policy.** A patient will be notified of the acquisition, access, use or disclosure of PHI in a manner not permitted under HIPAA which compromises the security or privacy of the PHI (a "Breach").

2. **Procedures.**

- Upon becoming aware of a Breach, the Practice will perform a risk assessment to determine the nature and extent of the PHI involved, the unauthorized person who used the PHI or to whom the PHI was disclosed, whether the PHI was actually acquired or viewed and the extent to which the risk has been mitigated.

- Notification will be made unless the risk assessment establishes that there is a low probability of compromise of the PHI or establishes that a reportable Breach has not occurred.

- The notification shall be made promptly and in a manner reasonably necessary, and shall contain such information as reasonably necessary to permit the Patient to mitigate any potential harm from the Breach.

- If the Breach involves more than 500 residents of a State, the Practice shall notify the Secretary of DHHS and prominent media outlets that service the State of the Breach.

- If the Breach involves fewer than 500 individuals, the Practice shall maintain a log of all Breaches and notify the Secretary of DHHS (in such form as designated) of all such Breaches.

D. **Breach Notification.** As described in Section C above, the Practice shall promptly notify the Patient, and if required under HIPAA, notify prominent media outlets that service the State and the Secretary of DHHS of the Breach.

E. **Risk Analysis.** The Practice shall require any Business Associates to periodically conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of EPHI held by the Practice or the Business Associate as necessary to meet the requirements of 45 CFR 164.306.

F. **Application.** This Amendment to the Practices Policies and Procedures is effective as of the Effective Date stated above. To the extent any of the existing Policies and Procedures are not modified by this Amendment, those Policies and Procedures remain in full force and effect.

ELECTRODIAGNOSIS & MUSCULOSKELETAL ASSOCIATES
OF PUGET SOUND

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MOTOR VEHICLE ACCIDENT POLICY AND MVA PATIENT AUTHORIZATION TO PAY ELECTRODIAGNOSIS

Patient Name: _____

Date of Birth: _____

Insured Name: _____

Insurance Carrier: _____

Claim Adjuster: _____

Claim Number: _____

Adjuster Phone Number: _____

As a courtesy to our patients, Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S. will bill the motor vehicle insurance for those patients with **proof of Personal Injury Protection.** In order to provide this service, we will need a current copy of the motor vehicle insurance card stating that you have this protection. If the motor vehicle insurance has not paid within sixty (60) days from the date of service, you will receive a statement and are responsible for immediate payment.

We do not provide third party billing nor do we accept liens on injury claim services.

I give Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S. permission to bill and receive payments from the above-mentioned insurance for medical services received by the providers at Electrodiagnosis & Musculoskeletal Associates of Puget Sound, P.S. Furthermore, I authorize the above-mentioned insurance carrier to release any and all information pertaining to my insurance coverage, including amounts remaining on my PIP, to the employees of Electrodiagnosis & Musculoskeletal Associates of Puget Sound, PS.

_____ _____
Signature of Insured Date

_____ _____
Witness Date