Thank you for choosing PT 360° and we look forward to being part of your health care team!
We participate with most major insurance providers.

All of our appointments are one hour of one on one time with your Physical Therapist, so please arrive with your paperwork and your PT will get you started at your appointment time.

Paperwork

In order for us to learn about your history, symptom complex and personal treatment goals and to be best prepared for your initial evaluation, we are enclosing new patient forms. Please complete the forms and bring them with you at the time of your appointment, or come a few minutes early to fill them out in our office. If you have a referral from your doctor, you can have them fax it to us or bring it with you. Our fax number is 503-200-1148.

Cancellation Policy

To avoid incurring a $70 late cancellation fee, please contact us at least 24 hours (1 business day) prior to your scheduled appointment. This requirement is waived if you are ill and infectious, or if there are dangerous weather/road conditions. Please refer to the Cancellation and Missed Appointment Policy on the Conditions of Registration Form.

Billing

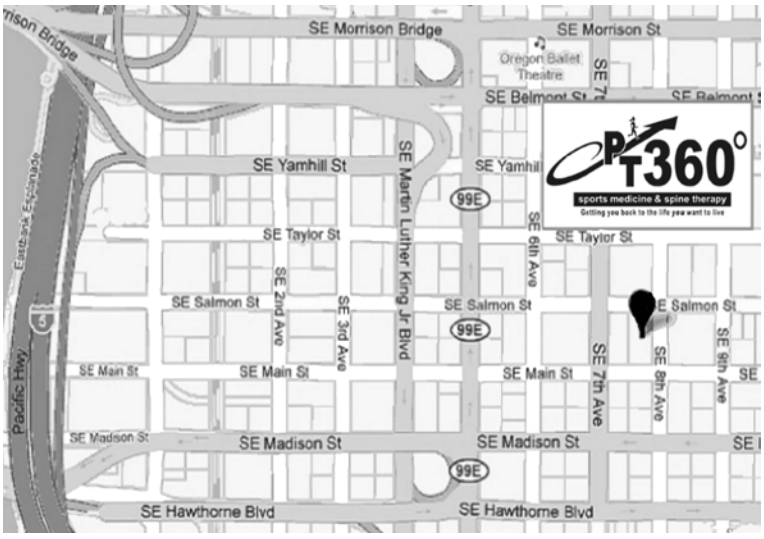
We offer billing services for worker's compensation, motor vehicle, Medicare claims and many private insurance companies. If your private insurance carrier is not included on our billing list, payment must be received on the day services are rendered. We accept cash, personal checks, Visa and MasterCard.

What to Wear

Please bring comfortable clothing, shorts or workout attire. Especially if we are looking at your lower back or legs.

Location

Our clinic is located at 1215 SE 8th Avenue on the corner of SE 8th and Salmon St. The building is a grayish green color, labeled "1215". There is available parking in the lot outside the building and free two-hour parking is located around the periphery of the building. If you're riding a bike, feel free to bring it into our office, there is space to park it during your appointment.



We are looking forward to becoming part of your health care team! If there is anything we can do to help, please feel free to ask.

Regards,

360° sports medicine and spine therapy staff

1215 SE 8th Ave., Suite D Portland, Oregon 97214 | Phone (503) 248-0360 | Fax (503) 200-1148
"Getting you back to the life ***you*** want to live."

Updated 6/2015

Patient Registration Form

PATIENT INFORMATION

Name _____ Social Security Number _____

Birthday_____ Gender: ☐ M / ☐ F ☐ Single ☐ Married ☐ Other_____

Address _____

City/State/Zip _____

Best contact: ☐ Home_____ ☐ Cell _____ ☐ Email _____

How should we contact you for appointment reminders? ☐ Email ☐ Phone ☐ Home ☐ No Reminders

INJURY INFORMATION

Date of Injury/Onset/Surgery: _____ Injury related to: ☐ Work ☐ Auto ☐Other_____

Body Part(s) Injured: _____

EMPLOYER INFORMATION

Professional Title/Occupation _____ Employer_____

Work Phone _____Okay to contact you at work? ☐ Y / ☐ N

Work Address_____

City/State/Zip _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Relationship to you _____

Emergency Contact Phone _____

PHYSICIAN INFORMATION

Referring Physician _____ Referring Physician Phone_____

Clinic Name/Location _____

Primary Care Physician_____ Phone _____

PRIMARY INSURANCE POLICY

Insurance Company _____ Phone _____

Identification/Member Number _____ Group Number_____

Subscriber's name (if not self) _____ Relation to patient _____

SECONDARY INSURANCE POLICY

Insurance Company _____ Phone _____

Identification/Member Number _____Group Number_____

If Motor Vehicle Accident or Work Claim, please fill out this section:

Insurance company_____ Claim Number_____

Adjuster Name _____ Adjuster's Number _____

PATIENT AGREEMENT – PLEASE READ CAREFULLY

I guarantee payment of all physical therapy charges for treatment provided to the above named patient to 360° sports medicine and spine therapy. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductibles and expenses not covered by my insurance. I understand that the unpaid balance is due upon completion of care, and there is a monthly finance charge of 1.5% (18% per annuum) applied to the unpaid balance after 30 days from discharge. If legal action is taken against this account, I agree to pay for all reasonable legal fees associated with this action. I agree to comply with the policies of said clinic as explained herein. **I understand that I must give 24-hour notice of cancellation if I am unable to keep a scheduled appointment.** In the event that an industrial or auto insurance exhausts or refuses to pay, I authorize 360° sports medicine and spine therapy to bill my health insurance. I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to 360° sports medicine and spine therapy and request that this assignment remain on file with my insurance carrier. I certify that a copy of this agreement shall be valid as the original.

_____ _____

Signature DATE

Patient Health Questionnaire – History

Name _____ Weight _____ Height _____ Age_____ Gender _____

Leisure activities, including exercise routine _____

_____

Occupation, including activities that comprise your workday _____

_____

Date of last complete physical? _____ **Do you smoke?** ☐ No ☐ Yes, Packs/Day_____ for how long? _____

Do you use caffeine? ☐ No ☐ Yes, cups/day _____ **Do you drink alcohol?** ☐ No ☐ Yes, Drinks/week _____

Are you latex sensitive? ☐ No ☐ Yes **Do you have a pacemaker?** ☐ No ☐ Yes

Allergies: List any medications you are allergic to _____

Have you RECENTLY noted any of the following? (Check all that apply)

☐ Fevers/chills/sweats	☐ Diarrhea	☐ Nausea/vomiting	☐ Shortness of breath
☐ Cough	☐ Numbness or tingling	☐ Falls	☐ Unexpected weight change
☐ Fainting	☐ Muscular weakness	☐ Bowel/bladder changes	☐ Heart burn/indigestion
☐ Fatigue	☐ Night pain	☐ Difficulty maintaining balance while walking	☐ Difficulty swallowing
☐ Dizziness/lightheadedness	☐ Constipation		

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections? ☐ No ☐ Yes, describe

_____

Have you EVER been diagnosed with any of the following conditions? (Check all that apply)

☐ Cancer	☐ Angina/chest pain	☐ HIV	☐ Bone or Joint infection
☐ Diabetes	☐ Hepatitis	☐ Thyroid Problems	☐ Pelvic Inflammatory Disease
☐ Heart conditions	☐ Depression	☐ Osteoporosis	☐ Chemical Dependency (i.e. Alcoholism)
☐ High blood pressure	☐ Lung Problems	☐ Multiple Sclerosis	
☐ Maladaptive pain response	☐ Tuberculosis	☐ Epilepsy	☐ Eye problems/Infection
☐ Obesity	☐ Asthma	☐ Liver Problems	☐ Bladder/UTI/Kidney Infection
☐ Blood Clots	☐ Pneumonia	☐ Polio	☐ Rheumatoid Arthritis
☐ Stroke	☐ Emphysema	☐ Ulcers	☐ Other Arthritic Conditions
☐ Anemia	☐ Bronchitis	☐ Sexually Transmitted Disease	☐ Other_____

Has anyone in your immediate family (parents, siblings) EVER been told they have any of the following?

☐ Cancer	☐ Diabetes	☐ Tuberculosis	☐ Angina/Chest Pain
☐ Heart problems	☐ Stroke	☐ Blood Clots	☐ Depression
☐ High blood pressure	☐ Arthritis	☐ Thyroid Problems	☐ Other _____

For your current problem, please check professionals you have received treatment from:

☐ Orthopedist	☐ Physiatrist	☐ Massage Therapist	☐ Other Physical Therapist
☐ Neurosurgeon	☐ Osteopath	☐ Acupuncturist	☐ Psychologist
☐ Surgery/Surgeon	☐ Chiropractor	☐ Naturopathic Physician	☐ Podiatrist

How often do you feel stress is a significant factor in your life? ☐ Never ☐ Seldom ☐ Regularly ☐ Always

---

Please list any medications/supplements you are currently taking (including pills, injection and/or skin patches) or bring your list with you.

_____

_____

Have you ever taken steroid medication for any medical condition? ☐ No ☐ Yes

Have you ever taken blood thinning or anticoagulant medication for any medical conditions? ☐ No ☐ Yes

Surgery(s), X-rays, MRI, CAT SCAN results relating to current injury:

1._____ 2._____ 3._____

Patient Health Questionnaire - Symptoms

What date (roughly) did your present symptoms start? _____
What do you think caused your symptoms? _____

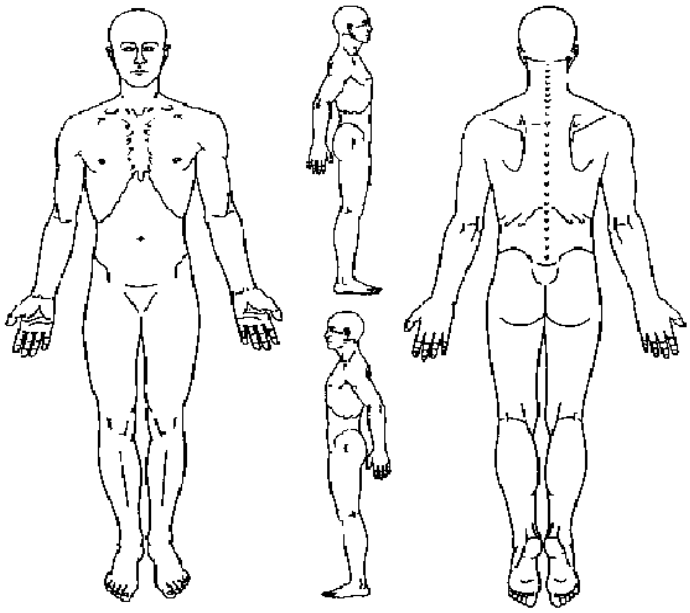
My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

I should not do physical activities that might make my pain worse: ☐ Disagree ☐ Unsure ☐ Agree

Have you ever had this problem before? ☐ No ☐ Yes, when _____treatment received _____
How long did it take for you to feel better? _____

Body Chart

Please mark the chart with areas where you are feeling symptoms with the following letters to describe your symptoms:



A = Ache
P = Pins and Needles
B = Burning
S = Stabbing
N = Numbness
O = Other

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Aggravating Positions / Activities. Identify up to 3 important positions or activities that make your symptoms worse:
1._____ 2._____ 3._____

Relieving positions/ Activities. Identify up to 3 important positions or activities that make your symptoms better:
1._____ 2._____ 3._____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

When are your symptoms **best**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

Using the 0 to 10 scale with 0 being "*no pain*" and 10 being the *"worst pain imaginable"* please describe:
Your current level of pain while completing this survey: _____
The **Best** your pain has been during the past 24 hours: _____
The **Worst** your pain has been in the past 24 hours: _____

Please describe your goals in attending physical therapy:

_____

_____

_____

CARE CONNECTIONS Initial Visit Progress Visit Discharge Visit **PATIENT WORKSHEET**

NAME _____ DATE _____

PROBLEM AREA (Check all that apply):

☐ Upper Extremity (A,D) ☐ Lower Extremity (B,F) ☐ Cervical/Thoracic (C,D) ☐ Lumbar (D,F) ☐ TMJ (C,E)

FUNCTIONAL INDEX

Part I: *Answer all five sections in Part 1.* ***Choose the one answer in each section that best describes your condition over the past 24 hours.***

WALKING

☐ Symptoms do not prevent me walking any distance.
☐ Symptoms prevent me walking more than 1 mile.
☐ Symptoms prevent me walking more than ½ mile.
☐ Symptoms prevent me walking more than ¼ mile.
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)
☐ I can do as much as I want to.
☐ I can do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all (only light duty).
☐ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)
☐ I can manage all personal care without symptoms.
☐ I can manage all personal care with some increased symptoms.
☐ Personal care requires slow, concise movements due to increased symptoms.
☐ I need help to manage some personal care.
☐ I need help to manage all personal care.
☐ I cannot manage any personal care.

SLEEPING

☐ I have no trouble sleeping.
☐ My sleep is mildly disturbed (less than 1 hr. sleepless).
☐ My sleep is mildly disturbed (less than 1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate_____)
☐ I am able to engage in all my recreational/sports activities without increased symptoms.
☐ I am able to engage in all my recreation/sports activities with some increased symptoms.
☐ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
☐ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
☐ I can hardly do any recreational/sports activities because of increased symptoms.
☐ I cannot do any recreational/sports activities at all.

ACUITY (Answer on initial visit)

How many days ago did onset/injury/surgery occur?

□ 0-15 □ 16-30 □ 31-60 □ 61-90 □ Chronic 91-120 □ Chronic >120

Part II: *Chose the one answer that best describes your condition in the sections designated by your problem area.*

A. UPPER EXTREMITY

CARRYING

☐ I can carry heavy loads without increased symptoms.
☐ I can carry heavy loads with some increased symptoms.
☐ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
☐ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
☐ I can carry very light weights with some increased symptoms.
☐ I cannot lift or carry anything at all.

DRESSING

☐ I can put on a shirt or blouse without symptoms.
☐ I can put on a shirt or blouse with some increased symptoms.
☐ It is painful to put on a shirt or blouse and I am slow and careful.
☐ I need some help but I manage most of my shirt or blouse dressing.
☐ I need help in most aspects of putting on my shirt or blouse.
☐ I cannot put on a shirt or blouse at all.

REACHING

☐ I can reach to a high shelf to place an empty cup without symptoms.
☐ I can reach to a high shelf to place an empty cup with some increased symptoms.
☐ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
☐ I cannot reach to a high shelf to place an empty cup but I can reach up to a lower shelf without increased symptoms.
☐ I cannot reach up to a lower shelf without increased symptoms but I can reach counter height to place an empty cup.
☐ I cannot reach my hand above waist level without increased symptoms.

B. LOWER EXTREMITY

STAIRS

☐ I can walk stairs comfortably without a rail.
☐ I can walk stairs comfortably, but with a crutch, cane, or rail.
☐ I can walk more than 1 flight of stairs, but with increased symptoms.
☐ I can walk less than 1 flight of stairs.
☐ I can manage only a single step or curb.
☐ I am unable to manage even a step or curb.

UNEVEN GROUND

☐ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
☐ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
☐ I have to walk very carefully on uneven ground without using a cane or crutches.
☐ I have to walk very carefully on uneven ground and require physical assistance to manage it.
☐ I am unable to walk on uneven ground.

C. CERVICAL/TMJ

CONCENTRATION

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty concentrating when I want to.
☐ I have a great deal of difficulty concentrating when I want to.
☐ I cannot concentrate at all.

HEADACHES

☐ I have no headaches at all
☐ I have slight headaches which come less than 3 per week.
☐ I have moderate headaches which come infrequently.
☐ I have moderate headaches which come 4 or more per week.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all of the time.

READING

☐ I can read as much as I want without increased symptoms.
☐ I can read as much as I want with slight symptoms.
☐ I can read as much as I want with moderate symptoms.
☐ I cannot read as much as I want because of moderate symptoms.
☐ I can hardly read at all because of severe symptoms.
☐ I cannot read at all.

D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING

☐ I can drive my car or travel without any extra symptoms.
☐ I can drive my car or travel as long as I want with slight symptoms.
☐ I can drive my car or travel as long as I want with moderate symptoms.
☐ I cannot drive my car or travel as long as I was because of moderate symptoms.
☐ I can hardly drive at all or travel because of severe symptoms.
☐ I cannot drive my car or travel at all.

LIFTING

☐ I can lift heavy weights without extra symptoms
☐ I can lift heavy weights but it gives extra symptoms.
☐ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
☐ My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
☐ I can only lift very light weights.
☐ I cannot lift or carry anything at all.

E. TMJ

TALKING

☐ I can talk without any increased symptoms.
☐ I can talk as long as I want with slight symptoms in my jaws.
☐ I can talk as long as I want with moderate symptoms in my jaws
☐ I cannot talk as long as I want because of moderate symptoms in my jaws.
☐ I can hardly talk at all because of severe symptoms in my jaws.
☐ I cannot talk at all.

EATING

☐ I can eat whatever I want without symptoms.
☐ I can eat whatever I want but it gives extra symptoms.
☐ Symptoms prevent me from eating regular food but I can manage if I avoid hard foods.
☐ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
☐ I cannot chew at all and maintain a liquid diet.

F. LUMBAR*/LOWER EXTREMITY

STANDING

☐ I can stand as long as I want without increased symptoms.
☐ I can stand as long as I want, but it gives me extra symptoms.
☐ Symptoms prevent me from standing for more than 1 hour.
☐ Symptoms prevent me from standing for more than 30 minutes
☐ Symptoms prevent me from standing for more than 10 minutes
☐ Symptoms prevent me from standing at all.

SQUATTING

☐ I can squat fully without the use of my arms for support.
☐ I can squat fully, but with symptoms or using my arms for support.
☐ I can squat ¾ of my normal depth, but less than fully.
☐ I can squat ½ of my normal depth, but less than ¾.
☐ I can squat ¼ of my normal depth, but less than ½.
☐ I am unable to squat any distance due to symptoms.

SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ My symptoms prevent me from sitting more than 1 hour
☐ My symptoms prevent me sitting more than ½ hour.
☐ My symptoms prevent me sitting more than 10 minutes.
☐ My symptoms prevent me from sitting at all.

**Lumbar questions adapted from Oswestry.*

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain  **Worst Pain Imaginable**

WORK STATUS

☐ No lost work time
☐ Return to work without restriction
☐ Return to work with modification
☐ Have not returned to work
☐ Not employed outside the home.
Days lost due to condition: _____days.

PLEASE DO NOT COMPLETE THE FOLLOWING SECTION ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (circle one)

-7	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6	7

Very Much Worse — Unchanged — Completely Recovered

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial_____

360° sports medicine and spine therapy

PROCEDURES AND FINANCIAL POLICY

OFFICE HOURS

To meet your individual needs, we offer early and late appointments. Our voice mail service will answer calls off hours and on weekends. **PLEASE CALL 911 IF THERE IS AN EMERGENCY.**

APPOINTMENTS and CANCELLATIONS

We realize unexpected situations do occur. If your schedule does change and you have to cancel your appointment, we do ask that you call in advance so that we may offer that appointment time to another patient. If you will be late, please call, as it may be necessary to reschedule your appointment time. If you miss 3 appointments without proper notice, your care may be terminated at your therapist's discretion. **WE DO CHARGE A $70 FEE, NOT COVERED BY INSURANCE, FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE OF THE PATIENT'S SCHEDULED APPOINTMENT TIME.**

PRIVACY POLICIES STATEMENT/ HIPAA

You will have an opportunity to review and question our privacy policies statement at your request. This statement will outline our policies that protect your privacy. We will release your personal health information for billing purposes to enable reimbursement for services rendered. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your account balance, and you will assume responsibility for submitting billings to your insurance carrier for reimbursement.

FINANCIAL INFORMATION

COPAYS AND COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. We will try to remind you at your appointment time to make sure fees are paid. **WE WILL MAKE EVERY EFFORT TO KEEP YOU APPRISED OF YOUR PATIENT FINANCIAL RESPONSIBILITIES IN A TIMELY FASHION WITH THE UNDERSTANDING THAT THIS WILL HELP PATIENTS PLAN FOR AND MEET FINANCIAL OBLIGATIONS.** We will make every attempt to verify your benefits, however, **WE DO RECOMMEND OBTAINING INSURANCE INFORMATION YOURSELF FROM YOU INSURANCE COMPANY, AS YOU ARE THE SUBSCRIBER AND INSURANCE REPRESENTATIVES MAY PASS ON MORE DETAILED AND UPDATED INFORMATION TO THEIR OWN CUSTOMERS**. We will bill your health insurance, pip or worker's compensation directly. Any remaining balance is the responsibility of the patient.

WE DO NOT BILL SECONDARY INSURANCE UNLESS THE PRIMARY INSURANCE IS MEDICARE.

ONCE YOUR INSURANCE IS BILLED AND PAYMENTS APPLIED, WE WILL BILL YOU FOR THE REMAINING BALANCE-- BALANCES UNPAID AFTER 30 DAYS—A SECOND NOTICE WILL BE SENT OUT; FOLLOWING THE SECOND NOTICE, YOU HAVE 15 DAYS TO RESPOND/PAY. IF WE HAVE NOT RECEIVED PAYMENT WITHIN THE 15 DAY TIME FRAME, A THIRD AND FINAL NOTICE WILL BE SENT OUT; FOLLOWING THE THIRD NOTICE, YOU HAVE AN ADDITIONAL 10 DAYS TO PAY BEFORE YOUR ACCOUNT WILL BE SENT TO COLLECTIONS.

ACCOUNTS SENT TO COLLECTIONS WILL BE SUBJECT TO AN INTEREST CHARGE OF 1.5% EACH BILLING CYCLE.
CHECKS RETURNED WITH NON-SUFFICIENT FUNDS WILL BE CHARGED A $35 FEE.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO COMPLY WITH THE POLICIES SET FORTH HERE.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of 360° sports medicine and spine therapy, LLC Physical Therapy Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at the time of each appointment. I understand that 360° sports medicine and spine therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the Company in writing. I also understand that 360° sports medicine and spine therapy, LLC, will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in 360° sports medicine and spine therapy, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

My signature does not indicate that I have read, understood, or agree with the Notice, only that it has been provided to me.

_____

PATIENT SIGNATURE

_____

DATE

Email Communication
Email communication is available with PT 360° for scheduling, billing and treatment-related questions.
PT 360° does not have encrypted email other than that provided by Gmail, though communications will be restricted to authorized personnel only with the correct login and password to our clinic email account.
To accept this form of communication, please sign below:

_____

PATIENT SIGNATURE

_____

I have attempted to obtain the patient's signature in Acknowledgment of this notice of Privacy Practices, but was unable to do so as documented below:

Date_____ Initials_____ Reason_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

360° sports medicine and spine therapy is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. 360° sports medicine and spine therapy is required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

360° sports medicine and spine therapy uses your personal health information primarily for treatment purposes; obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

360° sports medicine and spine therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/ statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

360° sports medicine and spine therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. 360° sports medicine and spine therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also contact the United States Department of Health and Human Services if you believe that we have violated your privacy rights. For further information on our health information practices or if you have a complaint, please contact the following person:

360° sports medicine and spine therapy
Attention: Privacy Officer
1215 SE 8th Ave, Suite D
Portland, Oregon 97214