

AXIS PHYSICAL THERAPY

21009 76TH AVE W EDMONDS, WA 98026
(425) 672-2910 FAX (425) 778-1872

Patient Information:

Email Address: _____@_____
Last Name: _____ First Name: _____ M.I. _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: (____) _____ - _____ Work Phone #: (____) _____ - _____ Cell Phone #: (____) _____ - _____
SS#: _____ - _____ - _____ Birth Date: ____ / ____ / ____ Sex: Male Female
Spouse/Domestic Partner Name: _____

Work Information:

Employer: _____ Work Phone: (____) _____ - _____ Ext: _____
Occupation: _____ Employment Status: Full Time Part Time Retired Not Employed

Care Provider Information:

Referring Practitioner: _____ Phone: (____) _____ - _____
Primary Care Provider: _____ Phone: (____) _____ - _____

Insurance Information (Please give insurance card to receptionist)

Primary Insurance: _____ Subscriber: _____ Birth Date: ____ / ____ / ____
ID #: _____ Group/Policy #: _____
Patient Relation to Subscriber: Self Spouse Child Other/Domestic Partner

Secondary Insurance: _____ Subscriber: _____ Birth Date: ____ / ____ / ____
ID #: _____ Group/Policy #: _____
Patient Relation to Subscriber: Self Spouse Child Other/Domestic Partner

Auto / Work Injury Claim (Please provide your health insurance information for back up)

Insurance Name: Auto: _____ Labor & Industries: _____
Adjuster / Claim Manager: _____ Phone: (____) _____ - _____ Ext: _____
Address: _____ City: _____ State: _____ Zip: _____
Claim #: _____ **Accident Date:** ____ / ____ / ____ **Cause:** _____

Attorney Information:

Name: _____ Law Firm: _____ Phone: (____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____

In Case of an Emergency:

Name of Local Friend or Relative (Not Living at the Same Address): _____
Relationship to Patient: _____ Best Contact Phone #: (____) _____ - _____

I authorize my insurance benefits be paid directly to Axis Physical Therapy, Inc. I understand that I am financially responsible for any balance or any non covered service. I also authorize Axis Physical Therapy, Inc to release any information required to process claims.

Patient/Guardian Signature

Date

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____, consent to the use or disclosure of my protected health information by Axis Physical Therapy for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Axis Physical Therapy. I understand that treatment I receive by a Physical Therapist or Massage Therapist may be conditioned upon my consent as evidence by signing my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment of healthcare operations of the practice. Axis Physical Therapy agrees to any restriction that I request, the restriction is binding on Axis Physical Therapy and Axis Physical Therapy employees.

I have the right to revoke this consent, in writing, at any time, except to the extent that Axis Physical Therapy and its employees have taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my Therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review Axis Physical Therapy Notice of Privacy Practices prior to signing this document. I certify that Axis Physical Therapy Notice of Privacy Practices has been provided to me. The notice of privacy practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performances of health care operations of Axis Physical Therapy. The Notice of Privacy Practices also describes my rights and Axis Physical Therapy’s duties with respect to my protected health information.

Axis Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy at the time of my next appointment, viewing it on the Axis Physical Therapy website or asking that one be sent in the mail.

Printed Name of Patient

Patient/Guardian Signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

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Medical History Form

General	Yes	No		Yes	No	
Hypertension or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		Severe Sprain/Strains	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Dislocation/Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness/Irritability/Depression	<input type="checkbox"/>	<input type="checkbox"/>		Tendonitis/Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>		Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>

Areas of Pain	Yes	No		Yes	No	
Neck/Head	<input type="checkbox"/>	<input type="checkbox"/>		Fainting/Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
Mid-Back/Scapulae	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis (type) _____	<input type="checkbox"/>	<input type="checkbox"/>
Low Back/Pelvis/Sciatica	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders/Elbow/Wrists/Hand/Finger	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hip/Thigh/Knee/Lower leg/Ankle/Foot	<input type="checkbox"/>	<input type="checkbox"/>		Gout	<input type="checkbox"/>	<input type="checkbox"/>
Chest/Ribs/Breastbone	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>

Muscle Conditions	Yes	No		Yes	No	
Muscle Spasm	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes/Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Pins & Needles Sensation	<input type="checkbox"/>	<input type="checkbox"/>		Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>		Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerve- Where? _____	<input type="checkbox"/>	<input type="checkbox"/>		Cancer (type) _____	<input type="checkbox"/>	<input type="checkbox"/>
“Slipped disk”- Where? _____	<input type="checkbox"/>	<input type="checkbox"/>		Have you previously had treatment for the condition you are being seen for today?	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Balance/ Difficulty Walking	<input type="checkbox"/>	<input type="checkbox"/>				

Lungs	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>

Habits

- Smoking Packs a Day _____
- Alcohol Drinks Per Week _____
- Coffee/Soda Cups a Week _____

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Stress Level

- Low
- Medium
- High

Exercise

- None
- 1-2 x week
- 3-4 x week
- 5+ x week

What types of exercise do you perform? _____

What things cause stress in your life? _____

When did you first start experiencing the symptoms for what you are being seen for today? _____

Are you taking any seizure medications? No Yes If yes, please list name: _____

Please list, or attach a list of, **ALL medications you are currently taking** including over the counter medications and herbals: _____

List all surgeries you have had in past years, including the dates: _____

Are you pregnant? No Yes If yes, what week: _____

Have you had any injuries related to work? No Yes If yes, please describe: _____

Have you had any Auto accidents? No Yes If yes, lists body part and date: _____

Have you had Physical therapy or Massage therapy before? No Yes If yes, where? _____

Patient/Guardian Signature

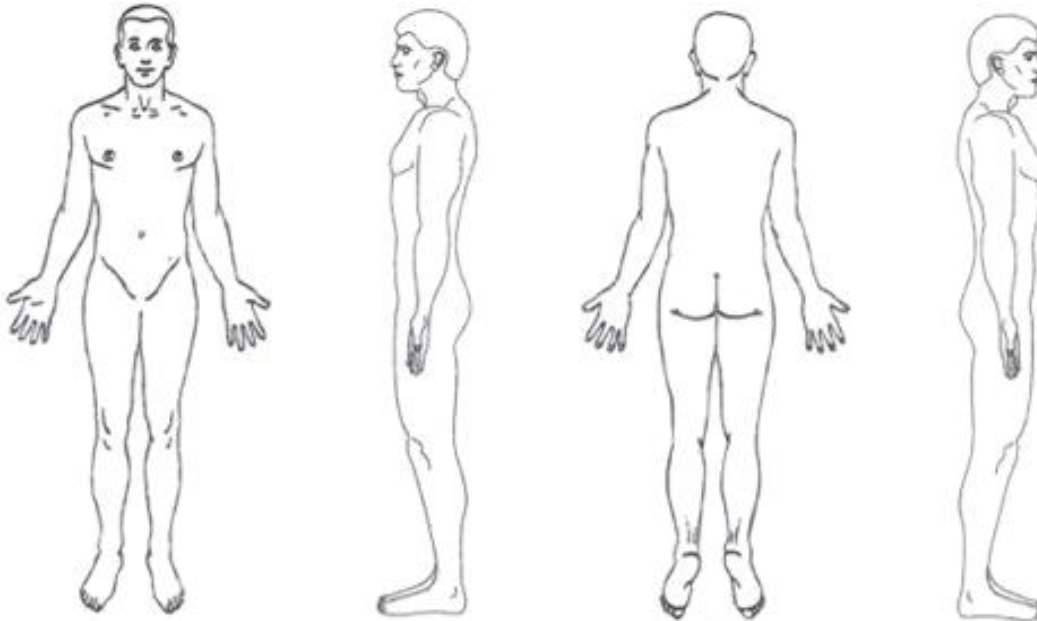
Date

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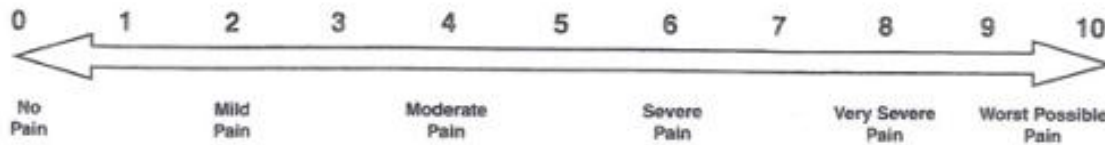
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Pain History & Subjective Assessment:

1. Please mark the areas of your body where you feel pain.



2. Please indicate the intensity of each area of pain with a number that corresponds to the scale below:



3. Please answer the following questions:

	Yes	No	Please Describe
Are you in pain today?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is the pain always there?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does it get worse when you move in certain ways?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do other things make it better or worse?	<input type="checkbox"/>	<input type="checkbox"/>	_____

What has your pain affected? (check all that apply) Mobility Exercise Sleep Work
 Concentration Social Activities Appetite Relationships Other: _____

Please describe all past treatments for your pain. Include prescription medications, over-the-counter medications, herbal and vitamin supplements, alternative treatments, and surgeries. _____

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Contact Information

Where would you prefer we contact you with **APPOINTMENT REMINDER** phone calls and/or **CONFIDENTIAL** information regarding your treatment?

Please leave as many numbers as possible where we can contact you or leave you a message.

#1 Home Cell Work
Number: (_____) _____ - _____
Voicemail okay?
 Yes No

#2 Home Cell Work
Number: (_____) _____ - _____
Voicemail okay?
 Yes No

#3 Home Cell Work Message
Number: (_____) _____ - _____
Voicemail okay?
 Yes No

You may also leave a message with: _____

Number: (_____) _____ - _____ Relationship: _____

In case of an emergency you may contact: _____

Number: (_____) _____ - _____ Relationship: _____

By signing below, I give permission for Axis Physical Therapy staff to contact me at the phone numbers I have listed above, as well as to leave confidential voicemail on the numbers I have authorized above by checking the "yes" box under "Voicemail okay?" next to each number.

Printed Name of Patient

Patient/Guardian Signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

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Contractual Agreement

I, the undersigned, fully understand and agree to the following terms and conditions of this contractual agreement:

As a courtesy, Axis Physical Therapy will do their best to verify and obtain benefit information from your insurance carrier. We highly encourage our patients to be involved in all aspects of their health care including contacting their insurance carrier to verify the information we have obtained is accurate, as the information reported to our office is not a guarantee from your insurance carrier regarding what your final benefit/payments will be. Ultimately, the financial responsibility of your health care belongs to you, the patient. Additionally, the carrier has a fiduciary responsibility to you as the subscriber/customer allowing you more rights in managing a correction of misquoted benefits than we, as your provider of service, are allowed or granted. Any accident policies, such as Personal Injury Protection, are an arrangement between the patient and the insurance carrier, Axis Physical Therapy is not a party to that contract. Our office will prepare any necessary reports and forms for processing your insurance claims. The patient is responsible for providing current and accurate insurance coverage information. In the event of a disputed claim by your insurance company, whereas a patient financial responsibility is being reported that is believed to be inaccurate, Axis Physical Therapy can offer assistance on your behalf, in resolving the billing/eligibility/misquote of benefits issues with your insurance company. During the time period of working to resolve the disputed information with your health insurance plan, monthly payments from you will be required on the pending account balance. Payment arrangements can be made, however, monthly rebilling fees will accrue on the unpaid account balance.

Communication is essential to keep your account with Axis Physical Therapy in good standing.

Based on an estimated average of our charges and prevailing insurance allowable amounts for a treatment session, your estimated co-insurance cost will be based on the percentage apportioned to you by your insurance company contract (Estimated examples: 10% = \$12 to \$15, 20% = \$24 to \$30, 30% = \$36 to \$45, etc). Our fees are usual and customary for the area. Our fees range from \$70.00 to \$270.00 per hour. Fees are determined by the procedures, modalities, and activities provided. We have preferred provider contracts with most insurance plans. It is their fee schedule and payment policies that will ultimately determine what your financial responsibility will be.

Returned checks will be subject to a \$35.00 dollar fee.

*****Cancellation Policy***** If you are unable to keep your appointment a 24 hours advance notice is required to avoid the \$65.00 Late Cancellation/ No-Show Fee. This fee cannot be billed to your insurance company, and you are solely responsible for this payment. If you miss three scheduled appointments, without appropriate notification, Axis Physical Therapy reserves the right to terminate your privileges in continuing your care at this clinic.

If your treatment at Axis Physical Therapy is elected to be suspended or terminated, all fees for professional services become immediately due and payable within sixty days. Unpaid balances after sixty days will be assessed a monthly re-billing fee. If your account is turned over to our collection agency you will be responsible for all fees related to their efforts in collecting on your unpaid account balance.

By signing below, I give this office limited power of attorney to endorse checks made out in my name from my insurance company, or any other entity, for service provided by this clinic to me, so that they may be credited to my account. I also hereby assign my insurance benefits to be paid directly to the health care provider.

I certify that the information provided herein is true and correct to the best of my knowledge. I fully understand and accept all the terms of this contract and give my signature here as testimony to full understanding and acceptance.

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Notice of Privacy Practices

This notice of Axis Physical Therapy's Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out and coordinate your treatment, obtain payment for services rendered, or for health care operations and other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

We are required to abide by the terms of this notice of privacy practices. We may change the terms of this notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request we will provide you with any revised copy in person or to be sent to you in the mail.

Uses and Disclosures of Protected Health Information

Uses and disclosures of protected health information based upon your written consent:

You will be asked by Axis Physical Therapy staff to sign a consent form. Once you consented to use and disclosure of your protected health information for treatment, payment and health care operations, by signing the consent form, our staff will use or disclose your PHI as described in this section. Your PHI may be used and disclosed by your therapist, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used/disclosed to secure payment for your health care bills, to support the operations of this practice.

Following are examples of the types of uses and disclosures of your PHI that Axis Physical Therapy is permitted to make once you signed your consent form. The examples are not meant to be exclusive or exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclosed your PHI to provide, coordinate, or manage your health care and/or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or third party insurance carrier for settlement purposes after an accident. We will also disclose your PHI to other physicians who may be treating you concurrently, for coordination of care. For example, your PHI may be provided to a medical practitioner to whom you have been referred to ensure that the practitioner has the necessary information to diagnose and/or treat you. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services from the insurance carrier responsible for payment of your services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, Worker's Compensation insurers and auto insurance companies require us to submit progress notes and all treatment notes for each date of service we request payment for.

Health Operations: We may use or disclose, as needed, your PHI in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

Additionally, we use a sign in sheet at the registration desk where you will be asked to sign in as you arrive with your first name and first initial of your last name. We may call your name in the waiting area when your therapist is ready to see you. We may use or disclose your PHI as necessary to contact you or leave a message as a reminder of your next appointment.

We will share your protected health information with a third party “business associate” that performs various activities (i.e. transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use and disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a postcard or newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our privacy officer to request that these materials not be sent to you.

Uses and Disclosures of protected health information (PHI) based upon your written authorization:

We may use and disclose your protected health information in the following instances; you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of all or part of PHI, then Axis Physical Therapy and/or your therapist may use professional judgment, to determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your immediate health care needs will be disclosed.

Others involved in your healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend and any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens our staff shall try to obtain your consent as soon as reasonably practical, after the delivery of treatment. If your therapist or another therapist in the practice is required by law to treat you and the therapist has attempted to obtain your consent, but is unable to obtain consent, he or she may still use or disclose your PHI to treat you.

Communication Barriers: We may use and disclose PHI if your therapist or another therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the therapist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Required by Law: We may use or disclose your PHI to the extent that Washington State and/or Federal law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury and disability. We may also disclose your PHI, if directed by the public authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government of applicable federal and state laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of abuse and/or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tracking of products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions, such as in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Research: We may disclose your PHI to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

Worker's Compensation: We may disclose your PHI as authorized to comply with worker's compensation laws and other similar legally established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500 et seq.

Your Rights: Following is a statement of your rights, with respect to your protected health information (PHI), and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy (copying fees apply) of PHI about you that is contained in a "designated record set," in the manner that we maintain your PHI. A "designated record set" contains medical and billing records and any other records that the practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to the PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact the Privacy Officer at Axis Physical Therapy.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction request and to whom the restriction request applies. This request must be in written form with your signature and the date of the request.

Your clinician is not required to agree with the restriction that you may request. If your clinician believes it is in your best interest to permit use and disclosures of your PHI, your PHI will not be restricted. If your clinician does agree to the request restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the clinic's privacy officer and submit the written request to become part of your designated record set.

You have the right to request and to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or the specification of an alternative address or other method of contract. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our privacy officer.

You may have the right to have your therapist amend your PHI. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your restatement and will provide you with a copy of any such rebuttal. Please contact our Privacy officer, to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures, if purpose other than treatment, payment or healthcare operations as described on this Notice of Privacy Practices. It excludes disclosures we may have made to you, for coordination of care, to a family member or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after June 01, 2006. You may request a shorter timeframe. The right to receive this information is subject to certain expectations, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice electronically.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy officer. We will not retaliate against you for filing a compliant

You may contact our Privacy Officer at (425) 672-2910 or submit a sealed envelope with your concerns to:

Axis Physical Therapy
Attn: Privacy Officer
21009 76th Ave West
Edmonds, WA 98026

This notice was published and becomes effective on June 01, 2006