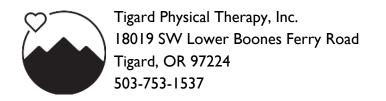


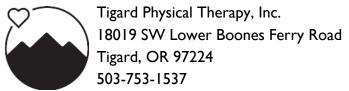
Full Legal Name:	
DOB:	Age:
Date:	

	Pationt I	nformation		
Driver's License #	State:			
Gender (circle): M F		•	e): M S [) W
			·	Zip:
Responsible Party:		•		1
How did you hear about Tigar				
,	, , ,	nformation		
Home #	Work #	Ce	·II #	
Email:				
Emergency Contact (required)	:	Relation:	Phone #	
Preferred Method for Appoint	ment Reminders (circle):	Text Message	Voice Call	Email
Insurance Company:				
Your Relationship to Subscribe		1		
Subscriber's Full Legal Name:	1			
· ·	nformation (Auto Accide			
Claim Number	•	Date of Injury:	,	
Insurance Company:				
Adjuster:		Phone #		
Nurse Case Manager:		Phone #		
Attorney:		Phone #		
E	mployer Information (V	Vorker Compensatio	n Only)	
Employer:				
Address:		City / State:		Zip:
Manager:		Phone #		



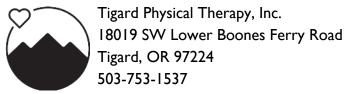
Full Legal Name:	
DOB:	Age:
Date:	

es .
surgeon:
No Yes No Yes



Full Legal Name:	
DOB:	Age:
Date:	

Patient Medical History Part 2 Please describe how your problem or injury began: Since your problem began, has it been getting worse, staying the same, or getting better? (circle) What activities or positions aggravate your pain or dysfunction? What makes your pain or dysfunction better? Are there activities you cannot do because of your pain or dysfunction? Please list: Are there activities you are able to do but are difficult because of your pain or dysfunction? Please list: When are your symptoms worst? (circle) Upon rising out of bed AM PM Varies with activity level Is your sleep disturbed by pain? □ No □ Yes How many times per night do you rise because of pain? Please mark your level of pain on the line below. Put an X on the best and worst pain level, and a * on current pain level. No Pain Moderate Pain Severe Pain Please mark on the diagram to the right where your symptoms are located and describe the symptoms: Are you aware of your diagnosis and prognosis as explained to you by your primary care provider? □ No □ Yes Based on your awareness, what are your rehabilitation goals and expectations from this program?

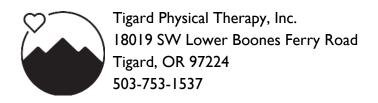


Center Representative/Witness:

Full Legal Name:	
DOB:	Age:
Date:	

503-753-1537	<u>Date:</u>
Consent	t for Care and Treatment
	or Tigard Physical Therapy, Inc. to furnish medical care and treatment to (print onsidered necessary and proper in diagnosing or treating his/her medical condition
Patient/Guardian/Responsible Party:	Date:
Benefit Assig	nment/Release of Information
private insurance, and third party payors to Tigard Physical	le major medical benefits to which I am entitled, including Medicare, Medicaid, I Therapy, Inc. A photocopy of this assignment is to be considered as valid as the mation necessary, including medical records, to secure payment.
Patient/Guardian/Responsible Party:	Date:
Finar	ncial Policy Statement
when the services are rendered. TPT requires that arrangem does not remit payment within 60 days, the balance will be	your insurance solely as a courtesy to you. You are responsible for the entire bill tents for payment of your estimated share be made today. If your insurance carrier due in full from you. In the event that your insurance company requests a refund on money refunded to your insurance company. In the event your company establishes responsible for the difference remaining.
If any payment is made directly to you for services billed by apy, Inc.	TPT, you recognize an obligation to promptly submit same to Tigard Physical The
· · · · · · · · · · · · · · · · · · ·	ered Worker's Compensation. However, be advised if you claim Worker's Compen- you will be held responsible for the total amount of charges for services ren
tronically debit your account for the amount of the check pla	sical Therapy, Inc., if your check is dishonored or returned for any reason, to elec- us a processing fee of up to the state maximum legal limit (plus any applicable sale rapy, Inc. cannot collect a returned check fee by other methods.
I understand and agree that if I fail to make any of the paym of collecting monies owed, including court costs, collection	ents for which I am responsible in a timely manner, I will be responsible for all cost agency fees, and attorney fees.
the care we provide, and for other healthcare operations. He quality of care. We have prepared a detailed notice of priva	and disclose your personal health information to treat you, to receive payment for ealthcare operations generally include those activities we perform to improve the cy practices to help you better understand our policies in regards to your personal time and we will always have copies available for distribution. The undersigned
I UNDERSTAND THE RESPONSIBILITY	FOR THE PAYMENT OF MY ACCOUNT.
Patient/Guardian/Responsible Party:	Date:

Date:



Full Legal Name:	
DOB:	Age:
Date:	

Acknowledgement and Consent

I understand that Tigard Physical Therapy, Inc. (referred to below as TPT) will use and disclose healthcare information about me.

I understand that my health information may include information both created and received by TPT, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions and similar types of health-related information.

I understand and agree that TPT may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, and coordinate along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare.
- Perform various office, administrative and business functions that support efforts to provide me with, arrange for and be reimbursed for quality, cost-effective healthcare.

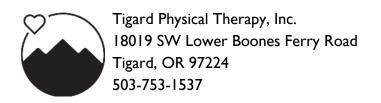
I also understand that I have the right to receive and review a written description of how the practice will handle health information about me. This written description is known as **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other personnel of TPT, and my rights regarding my healthcare information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of TPT's Notice of Privacy Practices in effect will be available in the clinic upon request.

I understand that I have the right ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that TPT is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices if I would like one.

Patient/Guardian/Responsible Party:	Date
Talletti/Quardiati/Nesponsiple Falty.	Date.



Full Legal Name:	
DOB:	Age:
Date:	

Credit and Payment Policies

We are pleased that you have chosen Tigard Physical Therapy, Inc. as your healthcare provider. Our goal is to provide you with the highest quality medical services at a reasonable cost.

As a courtesy to you, we are happy to submit your claims to all major insurance carriers and some secondary carriers. Your estimated financial responsibility will be assessed before you begin treatment. **Deductibles, copayments and/or coinsurance charges will be collected at the time services are rendered.**

It is important for you to understand that your insurance contract is between you and your insurance carrier, and that your benefits are subject to current plan provisions and eligibility at the time of service. By signing below, you acknowledge that <u>quoted benefits are an estimation</u>, and not a guarantee of payment by your insurance carrier. You will be held responsible for all charges not covered by your insurance, including but not limited to deductibles, copayments, coinsurance charges, and durable medical equipment. We are happy to help you understand your coverage, but **it is ultimately your responsibility to know the stipulations and limitations of your policy**.

Uninsured patients will be expected to pay for services in full at the beginning of their appointment. You may pay with cash, personal check, HSA Card, Visa, MasterCard, American Express, or Discover Card.

Patient/Guardian/Responsible Party:	Date:

Cancellation / No-Show Policy

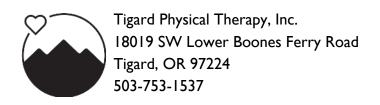
We strive to provide each patient with the highest quality of service in an expeditious manner; therefore, we provide a reserved time slot for each patient with a specific therapist to minimize waiting time and to assure continuity and quality of care.

In order to provide this service, we kindly ask that you call a **minimum of 24 hours in advance** if you are unable to keep a scheduled appointment. We ask for this courtesy so that we have time to offer your appointment time to another patient on our waiting list. If adequate notification is not given, **we reserve the right to charge a \$100.00 fee for late cancellations or missed appointments**. This fee will be collected prior to your next physical therapy appointment, and **cannot be billed to your insurance**.

All cancellations and/or "no-shows" will be documented in your medical record. Please note that three late cancellations or no-shows within a 30-day period may result in your discharge from physical therapy.

If you are a worker's compensation patient, your claims adjustor will be notified of your missed appointments. We appreciate the opportunity to serve you. Thank you for your consideration of our staff and other patients.

Patient/Guardian/Responsible Part	v:	



Visitor Name (printed):



Boom Fitness

18039 SW Lower Boones Ferry Road Tigard, OR 97224 (503) 684-8151

Tigard Physical Therapy, Inc. and Boom Fitness

Our physical therapy treatment programs often include exercise therapy; if appropriate for your care, your Physical Therapist will train you how to safely and effectively use various gym equipment to stretch and strengthen. Boom Fitness is an associate of Tigard Physical Therapy, Inc., and has kindly agreed to let our patients use their gym facilities free of charge when accompanied by a Physical Therapist or Physical Therapist Aide. Boom Fitness requires that all patients of Tigard Physical Therapy, Inc. read and sign the following waiver prior to using the gym. Signing the waiver does not commit you to a gym membership.

Visitor Waiver and Release of Liability

Visitor warrants to Boom Fitness that he/she has no disability, impairment, or ailment that prevents him/her from safely engaging in activity or any use of the premises that may be detrimental to his/her safety or health. Boom Fitness is not a medical facility. If Visitor has any doubt about his/her health, Visitor should consult with his/her physician before using the facility. Visitor warrants to Boom Fitness that he/she will not engage in any activity on the premises which may be detrimental to his/her health or safety. Visitor acknowledges that he/she will not hold Boom Fitness employees, management, or ownership liable for any injury or ailment as a result of use of the premises. Visitor rules and regulations of Boom Fitness. Any violation of the rules or regulations may result in expulsion from the premises.

I have read the above and understand that by signing below, I release Boom Fitness from any and all claims for liability arising out of any and all use of the club facilities, including but not limited to equipment and classes.

iignature:	Date:
Parental Consent (required for children under the	age of 18)
have read the above and understand that by sign all claims for liability arising out of any and all use	ing below, I release Boom Fitness from any and of the club facilities, including but not limited to
equipment and classes.	
Patient/Guardian/Responsible Party Name (printed):	
iignature:	Date: