Tigard Physical Therapy, Inc.
12700 SW Pacific Hwy
Tigard, OR 97223
503-753-1537

Full Legal Name: _____

DOB: _____ Age: _____

Date: _____

Patient Information

Driver's License # _____ State: _____ Expiration Date: _____

Occupation: _____ Gender (circle): M F Marital Status (circle): M S D W

Preferred Pronouns: _____

Address: _____ City / State: _____ Zip: _____

Responsible Party: _____ Relation: _____ Phone # _____

Contact Information

Home # _____ Work # _____ Cell # _____

Email: _____

Emergency Contact (required): _____ Relation: _____ Phone # _____

Preferred Method for Appointment Reminders (circle): Text Message Voice Call Email

Optional Email/Text Communication Statement (regarding email/text security): I, the undersigned, understand and accept the risk involved with email/text communication of my personal health information. I allow Tigard Physical Therapy, Inc. practitioners, it's billing agent, and office staff to initiate and respond to my email/text messages regarding matters related to my medical care. I am aware of the risk that any transmission of email or texts can be intercepted and read by a third party. I am also aware that all email/text communications may become part of my medical record. I understand that Tigard Physical Therapy, Inc. does not share email addresses or phone numbers with any third party. **Initial:** _____

Medical Insurance Information

Insurance Company: _____

ID # _____ Group # _____

Your Relationship to Subscriber (circle): Self Spouse Child Other

Subscriber's Full Legal Name: _____ DOB: _____

Claim Information (Auto Accident & Worker Compensation Only)

Claim Number: _____ Date of Injury: _____

Insurance Company: _____

Adjuster: _____ Phone # _____

Nurse Case Manager: _____ Phone # _____

Attorney: _____ Phone # _____

Employer Information (Worker Compensation Only)

Employer: _____

Address: _____ City / State: _____ Zip: _____

Manager: _____ Phone # _____

You're not done yet! Please complete all forms.

Tigard Physical Therapy, Inc.
18019 SW Lower Boones Ferry Road
Tigard, OR 97224
503-753-1537

Full Legal Name: _____

DOB: _____ Age: _____

Date: _____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Tigard Physical Therapy, Inc. to furnish medical care and treatment to (print name) _____ considered necessary and proper in diagnosing or treating his/her medical condition.

Patient/Guardian/Responsible Party: _____ Date: _____

Benefit Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Tigard Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party: _____ Date: _____

Financial Policy Statement

Tigard Physical Therapy, Inc. (referred to below at TPT) bills your insurance solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. TPT requires that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by TPT, you recognize an obligation to promptly submit same to Tigard Physical Therapy, Inc.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, *you will be held responsible for the total amount of charges for services rendered to you.*

When you pay by check, you expressly authorize Tigard Physical Therapy, Inc., if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). This does not, however, mean that Tigard Physical Therapy, Inc. cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: Tigard Physical Therapy, Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed notice of privacy practices to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND THE RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party: _____ Date: _____

Center Representative/Witness: _____ Date: _____

You're not done yet! Please complete all forms.

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503-753-1537

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: _____

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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 co-insurance 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 quoted benefits are an estimation, 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 by 3 PM the day prior to your appointment 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. **Initial:_____**

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 Party: _____ Date: _____

You're all done!!

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Date: _____

Patient Medical History Part 1

Referring Physician: _____ Primary Physician: _____

Date of injury/onset of problem: _____ Last date of work due to injury: _____

Occupation: _____ Are you right or left handed? _____

Please list any prescriptions, over-the-counter medications, or supplements you are currently taking:

_____

Are you allergic to any medications? ☐ No ☐ Yes Please list: _____

Do you have a latex allergy? ☐ No ☐ Yes

Please list any physicians you have seen or treatments you have had for this injury/problem:

_____

Have you had any diagnostic imaging for this injury/problem (X-Ray, MRI, CT-Scan)? ☐ No ☐ Yes

Please list type, date performed, and facility where performed: _____

Have you had surgery for this injury/problem? ☐ No ☐ Yes Please describe, give date and surgeon:

_____

Have you had any other surgeries? ☐ No ☐ Yes Please describe: _____

Do you have or have you ever had any of the following:

Asthma / Bronchitis (circle)	☐ No ☐ Yes	Headaches: tension / migraine (circle)	☐ No ☐ Yes
Emphysema	☐ No ☐ Yes	Vision / hearing problems (circle)	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes	Dizziness / fainting (circle)	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes	Bowel / bladder problems (circle)	☐ No ☐ Yes
Congestive Heart Disease	☐ No ☐ Yes	Weakness	☐ No ☐ Yes
High Blood Pressure	☐ No ☐ Yes	Weight / energy loss	☐ No ☐ Yes
Heart Attack	☐ No ☐ Yes	Eating disorders	☐ No ☐ Yes
Stroke / TIA (circle)	☐ No ☐ Yes	Hernia	☐ No ☐ Yes
Blood clot / emboli (circle)	☐ No ☐ Yes	Varicose veins	☐ No ☐ Yes
Epilepsy / seizures (circle)	☐ No ☐ Yes	Allergies, list: _____	☐ No ☐ Yes
Thyroid / goiter (circle)	☐ No ☐ Yes	Pins / metal implants: _____	☐ No ☐ Yes
Infectious diseases	☐ No ☐ Yes	Anemia	☐ No ☐ Yes
Diabetes, type I or II (circle)	☐ No ☐ Yes	Cancer, type: _____	☐ No ☐ Yes
Arthritis, type: _____	☐ No ☐ Yes	Chemotherapy / radiation (circle)	☐ No ☐ Yes
Gout	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes
Sleeping problems	☐ No ☐ Yes	Emotional / psychological problems	☐ No ☐ Yes
Current tobacco use	☐ No ☐ Yes	Current pregnancy, due date: _____	☐ No ☐ Yes
Multiple Sclerosis	☐ No ☐ Yes	AIDS / HIV	☐ No ☐ Yes
Fibromyalgia	☐ No ☐ Yes	Sexually transmitted disease	☐ No ☐ Yes

Please explain any "yes" answers and give dates:

_____

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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: _____

_____

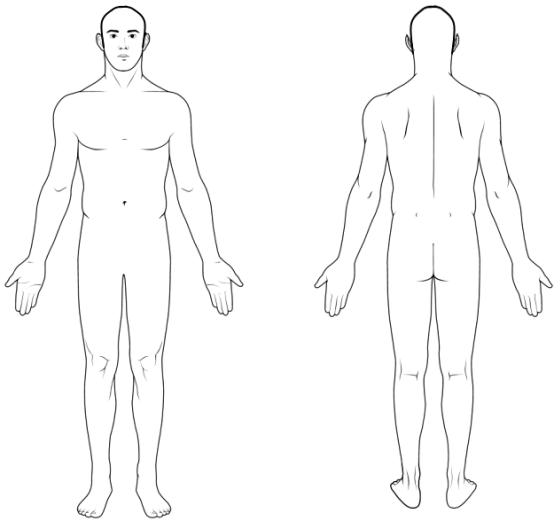
_____

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? _____

_____

_____



You're all done!