Corvallis Sport and Spine Physical Therapy, Inc.
2101 NW Professional Drive, Suite II, Corvallis, OR 97330
Phone: 541-752-0545 FAX: 541-757-0545

Patient Information

Last Name: _____ First Name: _____ MI: _____

Social Security: _____ Gender: _____ Date of Birth: _____

Marital Status: _____ Occupation: _____ Employer: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Would you like appointment reminders by email?: ❑Y ❑N

Home Phone: _____ Primary? ❑Y ❑N Work Phone: _____ Primary? ❑Y ❑N

Cell Phone: _____ Primary? ❑Y ❑N Would you like appointment reminders by text message? ❑Y ❑N

Emergency Contact: _____ Relationship: _____ Phone: _____

Who should receive statement *after* insurance is billed? _____

Billing Address (if different from above): _____

Would you like to receive the CSSPT Quarterly Newsletter via email from E-Rehab? ❑Y ❑N

May we leave a voicemail on your answering machine if necessary? ❑Y ❑N

How did you hear about Corvallis Sport and Spine Physical Therapy? _____

Private Insurance
Name of Insurance Carrier(s)

Please give your Insurance Card to the receptionist to be copied.

Please fill out the following only if applicable:

Auto and On the Job Injury		
Name of Insurance Carrier	Claim #	Date of Injury
Address		Adjuster Name
City, State Zip		Adjuster's #

Corvallis Sport and Spine Physical Therapy, Inc.
ASSIGNMENT OF BENEFIT, RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

I, the undersigned, assign directly to Corvallis Sport and Spine Physical Therapy, Inc. all medical benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I hereby authorize Corvallis Sport and Spine Physical Therapy, Inc. to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third party and that I may contact them with questions regarding my account.

I, the undersigned, voluntarily consent to physical therapy services at Corvallis Sport and Spine Physical Therapy, Inc. as ordered by my Physician and/or Therapist. I authorize Corvallis Sport and Spine Physical Therapy, Inc. to release my physical therapy records to my physician listed below.

Physician Name (required): _____

Patient Signature (or Guardian): _____ Date: _____

OBTAINING MEDICAL RECORDS

To obtain your medical records at any point during your treatment, please ask the front desk for a Release of Information form to sign.

I understand that by requesting a copy of my medical records, I am agreeing to pay a set-up fee of $35.00 for the first 10 pages plus an additional $0.30 per additional page. I understand that this payment will be due upon receipt of my requested records.

Requests are processed in the order in which they are received. The time it takes to complete your request can vary.

Patient Signature (or Guardian): _____ Date: _____

Authorized Facility Signature: _____ Date: _____

CORVALLIS
SPORT AND SPINE
PHYSICAL THERAPY

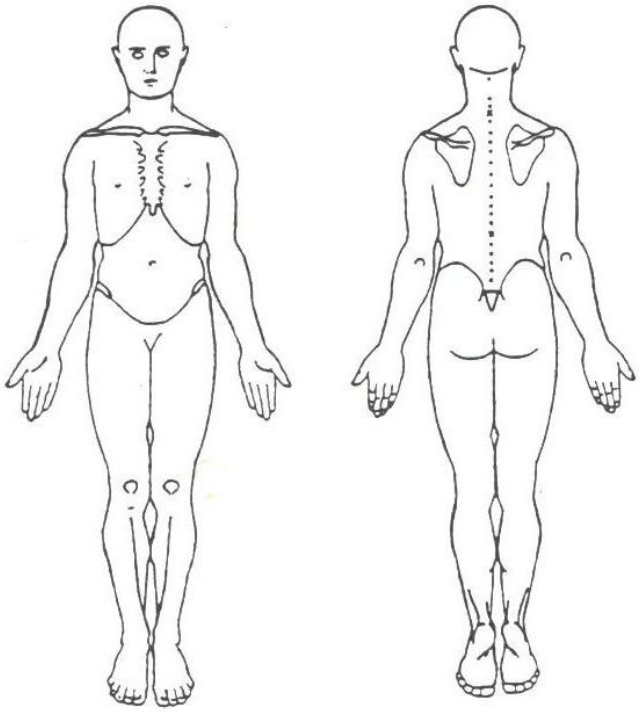
Orthopedic Initial Questionnaire

Name: _____

Date: _____

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. When did your symptoms start (date)? _____
2. Briefly describe how your symptoms began or how your injury occurred. _____
   _____
3. Date of first doctor's appointment for this injury or for these symptoms. _____
4. Have you had surgery for this injury? ❑ Yes ❑No If yes, when? _____
5. The onset of my symptoms was ❑ Gradual ❑ Sudden
6. What are your symptoms (i.e., pain, numbness, tingling)?
   _____
   _____
7. **Please mark on the body diagram where your symptoms are.** →



8. Type of pain?
   ❑ Sharp ❑ Dull ❑ Throb ❑ Ache ❑ Burning
9. My symptoms have
   ❑ worsened ❑ remained the same ❑ improved
10. My symptoms bother me
    ❑ constantly ❑ most of the time ❑ occasionally
11. My pain over the last few days has been (0-10) _____
12. What makes your symptoms worse? _____
    _____
13. What makes your symptoms better? _____
    _____
14. Since the onset of this injury, have your noticed any of the following:
    a. Regular numbness or tingling? ❑ Yes ❑ No If yes, where? _____
    b. Bowel/bladder control difficulties? ❑ Yes ❑ No
15. Have you had any imaging of your injury? ❑ Yes ❑ No If yes, when did you have your imaging? _____
    ❑ Xray ❑ MRI ❑ Bone Scan ❑ CT Scan ❑ Ultrasound
    What were the results? _____
16. Have you had this pain or problem before? ❑ Yes ❑ No
    If yes,
    a. Did you receive any treatment? ❑ Yes ❑ No If yes, did the treatment help? ❑ Yes ❑ No
    b. What did the treatment consist of? _____

17. What are your goals for physical therapy? _____

_____

18. Is there anything else about you or your condition that you would like us to know? _____

_____

Medical History

Allergies	❑Yes	❑No	Dizzy Spells	❑Yes	❑No	MRSA	❑Yes	❑No
Anemia	❑Yes	❑No	Emphysema/Bronchitis	❑Yes	❑No	Multiple Sclerosis	❑Yes	❑No
Anxiety	❑Yes	❑No	Fibromyalgia	❑Yes	❑No	Muscular Disease	❑Yes	❑No
Arthritis	❑Yes	❑No	Fractures	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Asthma	❑Yes	❑No	Gallbladder Problems	❑Yes	❑No	Parkinsons	❑Yes	❑No
Autoimmune Disorder	❑Yes	❑No	Headaches	❑Yes	❑No	Rheumatoid Arthritis	❑Yes	❑No
Cancer	❑Yes	❑No	Hearing Impairment	❑Yes	❑No	Seizures	❑Yes	❑No
Cardiac Conditions	❑Yes	❑No	Hepatitis	❑Yes	❑No	Smoking	❑Yes	❑No
Cardiac Pacemaker	❑Yes	❑No	High Cholesterol	❑Yes	❑No	Speech Problems	❑Yes	❑No
Chemical Dependency	❑Yes	❑No	High/Low Blood Pressure	❑Yes	❑No	Strokes	❑Yes	❑No
Circulation Problems	❑Yes	❑No	HIV/AIDS	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Currently Pregnant	❑Yes	❑No	Incontinence	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Depression	❑Yes	❑No	Kidney Problems	❑Yes	❑No	Vision Problems	❑Yes	❑No
Diabetes	❑Yes	❑No	Metal Implants	❑Yes	❑No			

Describe any other conditions or precautions. If none, please indicate so. _____

_____

Have you **recently** noticed any of the following?

WEIGHT GAIN/LOSS	❑Y ❑N	FATIGUE	❑Y ❑N	DIZZINESS	❑Y ❑N
NAUSEA/VOMITING	❑Y ❑N	WEAKNESS	❑Y ❑N	FEVER/CHILLS/SWEATS	❑Y ❑N
NIGHT PAIN	❑Y ❑N				

Fall History

Is this injury as a result of a fall in the past year? ❑Yes ❑No Have you had two or more falls in the past year? ❑Yes ❑No

If yes to either, please explain: _____

_____

Surgical History

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

On a scale from 1-10, How would you rate your overall health? (1= poor, 10= excellent)_____

What do you do for recreation? _____

What is your mode of exercise? _____

Corvallis Sport and Spine Physical Therapy, Inc.
Office Payment Policies

It is the policy of Corvallis Sport and Spine Physical Therapy that payment is due and to be made at the time service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are consistent with other clinics in the area. If you are covered by health insurance with physical therapy benefits, we will gladly bill your insurance for you. You will be asked to provide this information to the office manager upon your first visit and we will verify your coverage as a courtesy.

It is your responsibility to familiarize yourself with your particular benefit package as you know your policy better than we do. Occasionally, there are discrepancies in what you and the insurance company understand your policy to entail. We base our billing on the information the insurance company provides us.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not automatically guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred.** The physician referral and our verification of insurance benefit do not guarantee payment. Do not assume that you will not owe anything if you have more than one insurance policy. If you fail to give us your insurance information by your second visit, you will be billed for all charges.

Please initial that you have read and understand the following policies:

_____ **RETURNED CHECKS.** Returned checks will be charged a $45.00 fee.

_____ **BILLING INFORMATION.** Past due accounts (i.e., over 90 days) will be subject to a $10 re-billing fee. If no payment is received or your account is not made current, we will initiate collection procedures. Accounts sent to collections will be subject to a $100 billing fee. You will be responsible for all incurred fees related to the collection of your account including attorney, collection service, and court costs.

_____ **CANCELLATION AND NO-SHOW POLICY.** Should you not be able to make a previously scheduled appointment, a 24-hour notice of cancellation must be provided by phone, email or in person. **If notification of cancellation is not received 24 hours before the scheduled appointment, a $50 service charge will be billed directly to the patient for each cancellation. The $50 service charge will be assessed prior to receiving services at the next visit.** We at Corvallis Sport and Spine Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is the necessary part of the treatment process. **Patients who fail to show up for multiple appointments will be assessed the $50 service charge and all appointments made in advance will be cancelled.** If this occurs, the patient will only be allowed to schedule one visit in advance. Each patient will receive one "free" no show or cancellation before being charged. If you must cancel due to sickness or medical/family emergency, you will not incur a charge.

Please initial next to your payment method (choose one) and sign that you have read, understand, and agree with all of the information in this policy.

_____ 1. **CASH PAY.** We will be happy to accept cash pay patients and you will receive a **discount** off our fees. **Payment is due at the time service is rendered** and you will receive a receipt. If you have insurance and we are not a preferred provider, you may pay by cash and may be reimbursed by your insurance company if allowed. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service.

(continue on back)

_____ 2. **PRIVATE HEALTH INSURANCE.** Some insurance plans require authorization and/or a referral from your primary care physician. Most insurance companies have a deductible (i.e., amount paid by the patient before the insurance coverage begins) and either a co-pay (i.e, a set dollar amount per visit) or coinsurance (i.e., a percent of the allowed charges). **Deductibles, co-pays, and co-insurance payments are due at the time of service**. We will bill you for coinsurance or other balances due after we have been paid by your insurance company or notified of their denial for payment. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company.

_____ 3. **MEDICARE.** Corvallis Sport and Spine Physical Therapy, Inc. is a Medicare Preferred Provider. Medicare has an annual deductible of $147.00 for PT and Speech. Medi-Gap insurance covers the patient's portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company.

_____ 4. **WORKER'S COMPENSATION CLAIMS**. Authorization from your insurance adjuster is required before you can begin treatment. Please provide the name and number of your adjuster as well as your claim number, the date of injury and any other pertinent information. Remember, most worker's compensation carriers have up to 90 days to accept your claim. If they deny your claim, you are responsible for the balance. We will be happy to bill your personal health insurance company at that time. **If they deny your claim, you will be responsible for the entire balance.** Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your workers' compensation claim. Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change.

_____ 5. **THIRD PARTY PAYERS AND AUTO LIENS.** We will bill your insurance, however, third party payments will be sent to you for services we provide. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. You are responsible for payment of all services provided. Be sure to contact the office when your case is settled to ensure your account has been paid. Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid.

I have reviewed this office policy statement and discussed it with the office manager or my therapist. All of my questions have been answered to my satisfaction and I understand all of the information as explained to me.

Patient Signature (or Guardian): _____ Date: _____

Authorized Facility Signature: _____ Date: _____