CORVALLIS & ALBANY SPORT & SPINE PHYSICAL THERAPY

Patient Name: ______________________________ **Date of Birth:** _______________ **Today's date:** _______________________

This purpose of this form is to give your therapist a brief overview of your case before your appointment. Please answer the following questions to the best of your ability regarding your reason for seeking treatment.

Briefly describe your symptoms. If known, please describe how or why these symptoms began:

____

____

How long have these symptoms been present? _________________________________

What makes your symptoms better? ____

What makes your symptoms worse? ____

On a scale of 0-10, please rate your pain or symptoms below. (0 = no pain or symptoms, 10 = worst pain or symptoms possible)

At Rest: 0 1 2 3 4 5 6 7 8 9 10 **With Activity:** 0 1 2 3 4 5 6 7 8 9 10

Have you had previous treatment for this condition? Please describe that treatment. (If you had surgery for this condition, please include the date of surgery.)

____

____

What are you hoping to gain from physical therapy? List 2-3 goals if possible.

____

____

Are your symptoms related to a motor vehicle or workplace accident? ___________ **If yes, what was the date of injury?** ________

List any past surgeries you have had. (Please include the relevant body part and the date of surgery)

____

____

Medical History (check all that apply)

Anxiety	☐	Currently Pregnant	☐	History of Fracture	☐
Arthritis	☐	Depression	☐	Multiple Sclerosis	☐
Asthma	☐	Diabetes	☐	Osteoporosis/Osteopenia	☐
Autoimmune Disorder	☐	Fibromyalgia	☐	Rheumatoid Arthritis	☐
Cardiac Condition	☐	High/Low Blood Pressure	☐	History of Stroke	☐
Cardiac Pacemaker	☐	History of Cancer	☐	History of Thyroid Condition	☐
Latex Allergy	☐	Other Allergy: ____________	☐	Other Condition: _____________	☐

Current Medications

(Please provide medication list if possible)

1. ____
2. ____
3. ____

Patient Name: ________________________

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFIT, AND RELEASE OF INFORMATION

I, the undersigned, assign directly to Corvallis & Albany 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 & Albany Sport and Spine Physical Therapy, Inc. to release all information necessary to secure payments 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 & Albany Sport and Spine Physical Therapy, Inc. as ordered by my physician and/or Therapist. I authorize Corvallis & Albany Sport and spine Physical Therapy, Inc. to release my physical therapy records to my physician listed below.

Primary Care Physician Name: ____

Referring Doctor Name: ____

Patient (or Guardian) Signature: ___________________________________ Date: __________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

The privacy practices are listed on the back page of your clipboard; a physical copy can be provided upon request.

I, ______________________________, acknowledge that I have received a copy of Albany & Corvallis Sport & Spine Physical Therapy Inc.'s Notice of Privacy Practices.

____ _______________

Signature of Patient or Legal Guardian Date

FOR INTERNAL PURPOSES ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevents us from obtaining acknowledgement

____ Other (please specify): ____

Corvallis
2635 NW Rolling Green Drive, Corvallis, OR 97330
Phone: 541-752-0545 FAX: 541-757-0545

Albany
613 Hickory St NW, Albany, OR 97321
Phone: 541-928-1411 FAX: 541-928-7044

Patient Information

Last Name | First Name | MI | Preferred Name | Date of Birth | Gender

Mailing Address | City | State | Zip Code

Marital Status | Occupation | Employer

Email address

Primary Phone Number

Secondary Phone Number

Would you like to receive appointment reminders:

By email? Y ☐ N ☐

By text message? Y ☐ N ☐

By voice call? Y ☐ N ☐

Emergency Contact | Relationship | Phone Number

May we leave a voicemail on your primary phone voicemail if necessary? Y ☐ N ☐

Who should receive the statement *after* insurance is billed? ____

(If not you, please check all that apply to the responsible party) ☐ Guarantor ☐ Spouse ☐ Parent

Name | Relationship | Phone Number

Billing Address (if different from mailing) | Date of Birth

How did you hear about Sport and Spine Physical Therapy? ____

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

Auto and On the Job Injury

Name of insurance carrier	Claim #	Date of Injury
Address		Adjuster's name Adjuster's Phone
Employer's Name		Employer's Phone

OFFICE PAYMENT POLICIES

It is the policy of Corvallis & Albany 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. If you are covered by health insurance with physical therapy benefits, we will gladly bill your insurance for you.

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.** Do no 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 review 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.** If you must cancel due to sickness or medical/family emergency, you will not incur a charge.

Please review the following information regarding our office policy and your payment method.

CASH PAY: Payment is due at the time service is rendered. 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.

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.

MEDICARE: Corvallis & Albany Sport and Spine Physical Therapy, Inc. is a Medicare Preferred Provider. Medicare has an annual deductible for PT and Speech. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always.

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.**

THIRD PARTY PAYERS AND AUTO LIENS: We will bill your insurance, however, third party payments will be sent to you for services we provide.

By signing below, I attest that I have reviewed and agree to all of the information in this policy

Patient (or Guardian) Signature: ________________________________ Date: ____________________________

Patient Name (Printed): ______________________________________