SPORT & SPINE
PHYSICAL THERAPY
CORVALLIS • ALBANY • PHILOMATH

Patient Name: _____ **Pronouns:** _____ **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.

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

How long have your symptoms been present? _____

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

_____

Over the past 72 hours, please rate your pain/symptoms below. (0 = no pain/symptoms, 10 = worst pain/symptoms possible)

At worst: 0 1 2 3 4 5 6 7 8 9 10 **At best:** 0 1 2 3 4 5 6 7 8 9 10

What specific movements or activities make your symptoms worse? _____

What specific movements or activities make your symptoms better? _____

Have you had previous treatment or surgery for this condition? _____

_____

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

_____

Medical History (check all that apply)

Alzheimer's	☐	History of cancer	☐	Asthma	☐
Cardiovascular Disease	☐	Huntington's	☐	Autoimmune Disorder	☐
Cauda Equina Syndrome	☐	Immunosuppression	☐	Cardiac Pacemaker	☐
Cerebrovascular Accident (Stroke)	☐	Lupus	☐	Latex Allergy	☐
Current infection	☐	Muscular Dystrophy	☐	Currently Pregnant	☐
Diabetes Mellitus Type 1	☐	Osteoarthritis	☐	Low Blood Pressure	☐
Diabetes Mellitus Type 2	☐	Parkinson's	☐	Multiple Sclerosis	☐
Fibromyalgia	☐	Rheumatoid Arthritis	☐	Osteoporosis/Osteopenia	☐
Fracture or Suspected Fracture	☐	Traumatic Brain Injury	☐	Thyroid Condition	☐
High Blood Pressure	☐	Anxiety	☐	Other Allergy: _____	☐
		Depression	☐	Other Condition: _____	☐

Current medications (Please provide medication list, if possible): _____

_____

_____

What would you like to get back to doing? List 2-3 activities: _____

_____

_____

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

I, the undersigned, assign directly to Corvallis, Albany, & Philomath 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 they are reimbursed by my insurance company. I hereby authorize Corvallis, Albany, & Philomath 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, & Philomath Sport and Spine Physical Therapy Inc. as ordered by my physicians and/or Therapist. I authorize Corvallis, Albany, & Philomath 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 Corvallis, Albany, & Philomath Sport and 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 acknowledgement
__ An emergency situation prevents us from obtaining acknowledgement
__ Other (please specify): _____

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Patient Information

Last Name First Name MI Preferred Name Date of Birth Gender

Mailing Address

Marital Status Occupation Employer

Email Address

Mobile Phone Number

Home Phone Number

- Primary phone number: Mobile Home

-Would you like to receive appointment reminders via:

Email? : Yes No

Text Message? : Yes No

Voice Call? : Yes No

Emergency Contact Relationship Phone Number

May we leave a voicemail on your primary phone voicemail if necessary? Yes No

-Primary Insurance: _____ Member/Subscriber ID:_____

-Secondary Insurance: _____ Member/Subscriber ID:_____

-Tertiary Insurance: _____ Member/Subcriber ID: _____

-Worker's Compensation- Insurance Name: _____ Claim Number: _____

-Motor Vehicle Accident- Insurance Name: _____ PIP Claim Number:_____

-Who should receive any statements/bills that remain after insurance is billed? Patient or Other

-If other- Relationship:_____ Name:_____

DOB: _____ Phone Number: _____

Address (*if different than the mailing address*):_____

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

Would you like to receive the Quarterly Newsletter via email from E-Rehab? Yes No

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OFFICE PAYMENT POLICIES

It is the policy of Corvallis, Albany, & Philomath Sport and Spine Physical Therapy that payment is due and to be made at the time of 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 with.

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 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 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 fees incurred 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, 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 $75 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 it is 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 percentage 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 of payment.

MEDICARE: Corvallis, Albany, & Philomath 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's 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 workers' 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 the services we provide.

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

Patient (or Guardian) Signature: _____ Date: _____

Patient Name (Printed): _____