Advanced Orthopedic
Physical Therapy, P.C.

Thank you for choosing Advanced Orthopedic and Welcome! Please provide your insurance and identification card for our records.

Name: _____ DOB: _____ Male: ☐ Female: ☐

Current Diagnosis: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone/Address: _____

Referring Physician: _____ Phone/Address: _____

Employment Information:

Employer: _____ Phone #: _____

Occupation: _____

How did you hear about us? Physician ☐ Personal Referral ☐ Advertisement ☐ Other ☐

Have you been here before? Yes ☐ No ☐

Injury Information:

Sport ☐ Auto ☐ Work ☐ Other ☐ Date of Injury: _____

Patient Name: _____ **DOB:** _____

Medical History: (check all that apply)

- ☐ Arthritis (Rheumatoid/Osteoarthritis)
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Other: _____
- ☐ Chest Pain
- ☐ Coordination Problems
- ☐ Difficulty Sleeping
- ☐ Headaches
- ☐ Loss of Balance
- ☐ Visual Problems
- ☐ Currently Pregnant

Prescription Medications: _____ Height: _____

Surgical history: _____ Weight: _____

History of Current Problem:

When did the problem(s) begin? _____

What happened? _____

_____

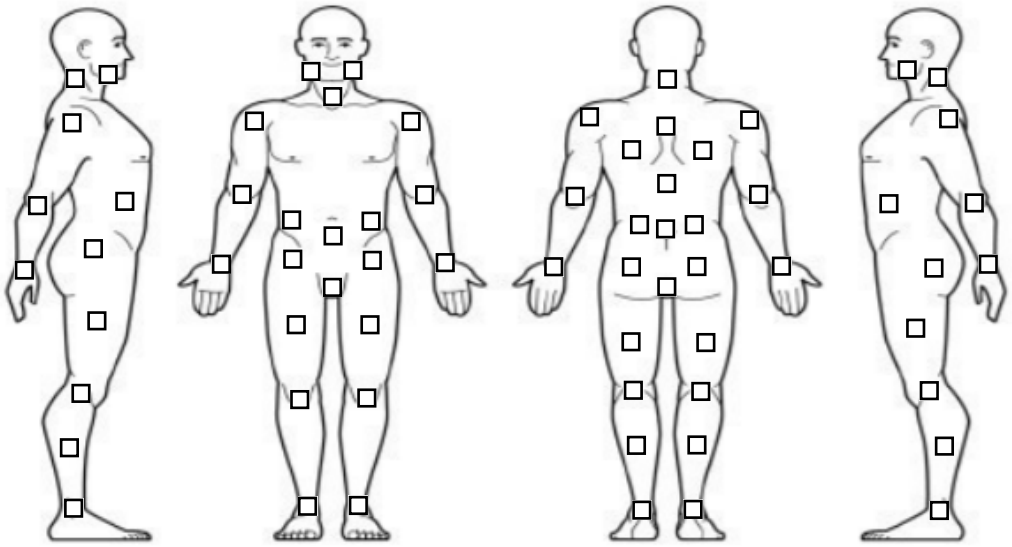
Have you had this problem(s) before? Yes: ☐ No: ☐

What makes this problem(s) better? _____

What makes this problem(s) worse? _____

Please rate your pain level on a scale of 0-10 and sketch the areas of pain on the diagram below:

0 – No Pain
1 –
2 –
3 – Moderate
4 –
5 – Strong
6 –
7 – Intense
8 –
9 –
10 – Emergency



Current pain rating:_____

Last 30 days: _____

Advanced Orthopedic
Physical Therapy, P.C.

Thank you for choosing Advanced Orthopedic! Please read the following form and sign at the bottom.

CONSENT TO PHYSICAL THERAPY AND/OR OCCUPATIONAL THERAPY INTERVENTION:

I hereby authorize the healthcare providers of Advanced Orthopedic Physical Therapy to administer Physical Therapy and/or Occupational Therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that Physical and Occupational Therapy interventions may include, but are not limited to: electrical/thermal modalities, therapeutic exercise, hands on manual therapy and manipulation and instrument assisted soft tissue mobilization. I understand that every attempt to explain each intervention will be made by the treating clinician. I acknowledge that I have the right to inquire about the clinical rationale for each intervention performed. I understand that Physical Therapy and/or Occupational Therapy are voluntary healthcare services and I, or the treating clinician, may choose to discontinue any intervention at any time. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the Physical Therapy and/or Occupational Therapy intervention.

FINANCIAL RESPONSIBILITY:

I authorize Advanced Orthopedic Physical Therapy, PC to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Advanced Orthopedic Physical Therapy, PC will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts. I agree that, if my account is put into the hands of an attorney for collections, I will be solely responsible for any and all attorney's fees and costs associated with collecting the overdue amount, whether before a lawsuit is filed, at trial, or on appeal.

By signing this form on the last page, I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance of my account for any professional services rendered.

CANCELLATION POLICY:

Advanced Orthopedic Physical Therapy, PC takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited.

<u>Any appointment not cancelled within 24 hours of the appointment time, will incur a fee of $40.</u>

If more than 2 cancellations/no shows occur within a patient's recommended plan of care timeframe, Advanced Orthopedic Physical Therapy, PC will hold the right to recommend discontinuing therapy services. The patient will then be removed from their therapist's schedule to allow for other individuals to use this time slot.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(II), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1196 (the "Privacy Regulations").

Please read the following information carefully:

a) I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Advanced Orthopedic Physical Therapy, P.C (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

b) I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

c) I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 700 Deborah Rd. Newberg, OR 97115, Attention: Practice Compliance Director.

d) I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by the restriction until I notify it otherwise in writing.

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name