TODAY'S DATE: ____/____/ 2017

Pearl
Beaverton
Tigard
Mall 205
Hillsboro
Milwaukie

c.h. PHYSICAL THERAPY
MOVE in the RIGHT direction

*** CONFIDENTIAL ***

Last name: _____ First: _____

Address: _____ City/state/zip: _____

Age: _____ DOB: _____ SSN: _____

Email: _____ Married: Yes No Sex: M F

Preferred contact phone #: _____

Preferred contact for appointment reminders: email phone text none

Emergency contact and phone #: _____

Employer: _____ How you found us: _____

Physician: _____ Is this physician your PCP? Yes No

If not, name of PCP: _____ Last PCP visit: _____

Primary reason(s) for coming to PT: _____

_____

Is this PT service related to a motor vehicle/worker's compensation accident? Yes No

If yes, date of accident: __/____/____ Adjuster name: _____

Have you had PT before? Yes No If yes: when, why and was it helpful? _____

_____

Past medical history: _____

Medications: _____

When was the last time you followed an exercise/stretching plan? _____

Would you like your PT to help you develop healthy eating habits (no charge)? Yes No

Consent for Treatment, Operations and Notice of Privacy

I consent to the use and disclosure of my protected health information (PHI) by c.h. PT for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills and/or to conduct business.

I understand that diagnoses/treatment of me by c.h. PT is conditioned upon my consent as evidenced by my signature below. I have the right to request a restriction as to how my PHI is used/disclosed to carry out treatment, render payment and/or business of the practice, If c.h. PT agrees to a restriction request, the restriction must be in writing and will bind c.h. PT and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that c.h. PT/its providers have taken action in reliance on this consent.

PHI refers to health information (including demographic information), collected from me and created and received by my physicians, another healthcare provider, health plans, my employer and/or healthcare clearinghouse. This PHI relates to my past, present and future physical and mental health condition.

Signed: _____

Informed Consent

I certify that the information provided is true to the best of my knowledge. I understand that it is my responsibility to inform c.h. PT of any changes in my health status, physical condition and/or personal data.

If applicable, I agree to inform c.h. PT of secondary insurance (we will bill all visits to your primary & secondary insurance, but are not responsible for billing secondary insurance if we are not told prior to care that you have it). I understand that secondary insurance companies are billed once as a courtesy to me and that I will be personally responsible for any remaining balance after all insurance reimbursements have been paid.

PT PATIENTS: I authorize my providers and/or managed care organizer to release any information required to process my insurance claims. I understand that if my insurance company, WC or auto carrier does not fully reimburse c.h. PT, I will be billed for the remainder of the balance due, in which I will be responsible for payment of all outstanding amounts within thirty (30) days of the billing statement date unless other payment arrangements are made in writing. I also understand that I will be responsible for any costs, fees and disbursements (including legal fees) should c.h. PT engage in collection for any balances due. I also consent to the release of any trust agreement funds to c.h. PT in the event claims have not yet been paid and authorize the use of the signature below on all insurance submissions should my signature be required.

PERSONAL TRAINING CLIENTS: I understand that the $55 initial consultation fee, $80 training session fee (1 person) or $110 training fee (2 people) is due at the time of service and that I will be responsible for any costs, fees and disbursements (including legal fees) should c.h. PT engage in collection for any balances due on my account.

CANCELLATION POLICY: I understand that if I do not provide at least 24 hours notice in the event I cancel or fail to show for a scheduled PT appointment, a $55 charge may apply. I understand that if I arrive 10 minutes or later for an appointment, it's at the physical therapist's discretion that my appointment be rescheduled and apply a $55 charge. I understand that if I do not provide at least 24 hours notice in the event I cancel or fail to show for a scheduled training appointment, I will be charged $80 (training, 1 person) or $110 (training, 2 people). I understand that I am responsible for paying training fees at the time of service and cancellation fees can be avoided if the missed/canceled appointment is rescheduled on the same day as the original appointment at the sole discretion/availability of the PT.

Signed: _____