

Step & Spine Physical Therapy, LLC
PO Box 1510
Sisters, OR 97759

PATIENT REGISTRATION

CHART # _____

Date _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Address _____
STREET/PO BOX CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Social Security # _____ Gender: M F

Date of Birth _____ Marital Status: Single Married Divorced Widowed

Employment Status: Full Time Part-Time Not Employed Retired Student

Employer _____ Occupation _____

Employer Address _____

Referring Doctor _____ Primary Care Doctor _____

Emergency Contact Name _____ Phone _____

IF YOUR INJURY WAS JOB RELATED, FILL OUT THIS SECTION

Employer when injured _____ Date of Injury _____

Employer's Workers Comp. Carrier _____ Claim # _____

Workers Comp. Carrier Address _____

Workers Comp. Carrier Phone _____ Claim Status: Open Closed New Disputed

IF YOUR INJURY WAS FROM A MOTOR VEHICLE ACCIDENT, FILL OUT THIS SECTION

Your Auto Insurance Carrier _____ Phone _____

Auto Insurance Carrier Address _____

Name of Insured _____ Date of Injury _____ Claim # _____

Adjuster Name _____

FOR ALL OTHER INSURANCE CLAIMS, FILL OUT THIS SECTION

Primary Insurance Company Name _____ Phone _____

Primary Insurance Company Address _____

Name of Insured _____ ID# _____ Group # _____

FOR **SECONDARY INSURANCE** COVERAGE, FILL OUT THIS SECTION

Secondary Insurance Company Name _____ Phone _____

Secondary Insurance Company Address _____

Name of Insured _____ ID# _____ Group # _____

Payment Agreement

I understand that payment for all therapy services is my responsibility regardless of the insurance or other third party coverage.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. It is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance on your account, your money will be promptly refunded to you or your insurance company.

A monthly statement will be sent to you. We accept payment by cash, check or money order. Past due accounts, over 60 days, will be subject to a monthly rebilling charge. Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 90 days. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts.

For claims in pending litigation (or dispute as to the responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made or if the balance becomes untenable.

Medicare – we accept Medicare assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

I authorize payment of medical benefits to Step & Spine Physical Therapy, LLC, and I have read and understand this payment agreement.

Consent to Treat and Authorization to Release Information

I voluntarily consent to *evaluation and treatment* by Step & Spine Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the *release of information* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

I authorize *phone messages* regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

A copy of this facility's *Statement of Privacy Notice* has been provided to me.

“No Show” Policy

Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a “no-show.” A no-show patient is charged a fee, as set by Step & Spine, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from Step & Spine.

By signing below, I certify that I have read the *Payment Agreement, Consent to Treat and Authorization to Release Information, and “No Show” Policy* sections above and agree to all statements contained therein.

Patient's Signature _____ Date _____

Signature of Responsible Party _____ Relationship _____ Date _____
(if different than patient)

PATIENT HISTORY QUESTIONNAIRE

Date _____ CHART # _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not employed

I currently: Live alone Live with caregiver Live with family members

Current living environment: Home/apartment Retirement home Assisted living

Do you smoke? Yes No Packs per day _____ Do you drink alcohol? Yes No Drinks per week _____

Do you exercise? Yes No Type _____ Times per week _____

Interests/hobbies/exercise _____

Will you have any problems attending therapy sessions? Yes No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation/Vascular Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> High Cholesterol/Lipids | <input type="checkbox"/> Recent Hospitalization | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Panic Attacks/Anxiety | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Stomach Disease/
Ulcer/Reflux | <input type="checkbox"/> Stroke/Paralysis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Visual Problems | |
| <input type="checkbox"/> Surgery – type(s) _____ | | | | |

If female, are you currently pregnant? Yes No

Are you taking any medications? Yes No If yes, please list _____

Have you had any prior treatments for your current condition (check all that apply)?

- | | | | | |
|--|---|---|--------------------------------------|--|
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Bracing/Taping/Casting | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Surgery | <input type="checkbox"/> TENS/Stimulation Unit |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Chiropractics | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other _____ | |

Are you having trouble sleeping? Yes No Normal hours of sleep: _____ hours Current hours of sleep: _____ hours

PREVIOUS FUNCTIONAL LEVEL

Before the onset of my current symptoms (or prior to injury), I was: Independent in all activities Dependent for all care

Independent with self-care only Needing assistance with some activities Needing assistance with most activities

PERSONAL GOALS FOR THERAPY

What do you want to achieve from having therapy? Reduce Pain Increase Function Return to Work

Return to usual housework/yard work Return to recreation, types _____

Sleep without waking up Other _____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your MAIN complaint? _____

Darken the areas on the body where you are having problems:

Please mark your level of pain with an X along the following lines:

What is your level of pain at rest?

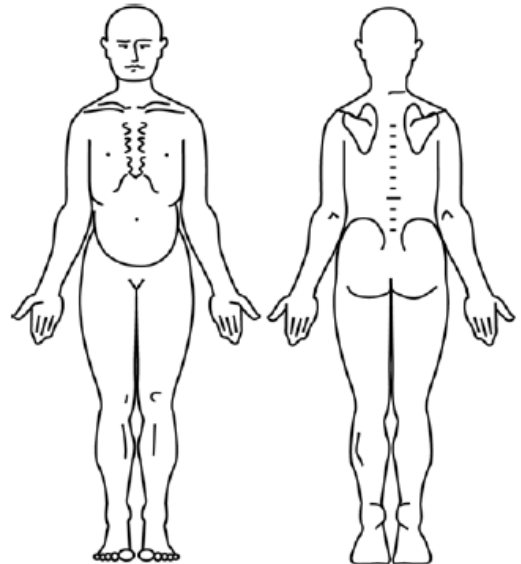


What is your pain with activity?



How would you describe your pain (check all that apply)?

- Aching Burning Cramping Crushing Discomfort Dull
- Gnawing Loss of Sensation Numbness Pressure Sharp
- Stabbing Stinging Swollen Throbbing Tight Tingling Weakness Other _____



When and how did these symptoms begin? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Since the onset of your symptoms have you had any of the following (check all that apply)? Significant, unexplained weight loss

- Atypical night pains Impaired bowel/bladder function Pain in multiple areas Dizziness/fainting Muscle weakness
- Fever/chills Numbness Visual/Hearing Problems

STATEMENT OF PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review this information carefully.

- I understand that my protected health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
- Your protected health information may be released to your insurance provider for the purpose of Step & Spine Physical Therapy, LLC ("Step & Spine") receiving payment for providing you with needed physical therapy services. Step & Spine might share your health information with your physician for payment activities related to the care you received.
- Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be released to other healthcare providers in the event you need emergency care.
- Information regarding your appointment time, presence at our facility, or other general details of your scheduled appointments may be provided over the phone to caller's who request so by providing your name.
- Your protected health information may be released only after receiving written authorization from you with the exception of those listed above or for treatment, payment, or healthcare operations. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. Step & Spine is not required to agree to your request.
- You may be contacted by Step & Spine by phone or mail (or leave a message on an automated answering device) to remind you of appointments, verify insurance/demographic information, etc. You have the right to request a more confidential way of providing your protected health information or alternative communication method at the time you are seen at Step & Spine. Step & Spine will honor all reasonable requests.
- You have the right to restrict the use of your protected health information. However, Step & Spine may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- You have the right to review and photocopy any/all portions of your health information. Step & Spine has the right to assess a fee for the photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. Step & Spine can deny the amendment and if so, a written explanation will be provided.
- You have the right to possess a copy of this Statement of Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Step & Spine is required by law to protect the privacy of its patients. It will keep protected any and all patient health information and will provided patients with a list of practices that protect health information upon request.
- Step & Spine will abide by the terms of this notice. Step & Spine reserves the right to make changes to this notice and will continue to maintain the confidentiality of all health information. Changes to this notice will be redistributed at your next visit to Step & Spine
- You have the right to complain to Step & Spine if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to: Step & Spine Physical Therapy, P.O. Box 1510, Sisters, OR 97759
- All complaints will be investigated. No personal issue will be raised by filing a complaint with Step & Spine.
- You may also file a complaint to: Region IV, Office of Civil Rights, US Dept. of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909

If you would like more information regarding this Privacy Notice, please contact our office at 541-977-5559.