Newport Physical Therapy

1010 SW Coast Highway
Newport, OR 97365

Last Name:_____ First Name: _____Middle:_____

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

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Physician:_____

Employer:_____ Address:_____ Work Phone:_____

Date of Birth:_____ Social Security #:_____ Email:_____

Emergency Contact: Name_____Contact Number_____
Relationship To Patient:_____

Primary Insurance

Primary Insurance:_____ Subscriber's Name:_____

Subscriber ID #:_____ Subscriber DOB:_____ Group #:_____
(If you're not the card holder please give card holders info this is very important)

Secondary Insurance

Secondary Insurance:_____ Subscriber's Name:_____

Subscriber ID #:_____ Subscriber DOB:_____ Group #:_____

Automobile Accident/Workers Compensation

Injury caused by: Auto Accident: Y or N Workers comp: Y or N Date of Injury:_____

Insurance Company:_____

Claim Number: _____Contact:_____ Phone:_____

Name of Insurance company to bill:_____

I have read this in its entirety and agree to the above statements; also, all patients and insurance information I have given above is correct to the best of my knowledge.

_____ Date:_____
Signature of Patient or Guardian (if patient is under the age of 18)

Patient Medical History

Name:_____ Referring Physician:_____

Primary Care Physician:_____ Date of last visit with PCP:_____
Date first Dr. Visit for the injury/episode:_____ Last day worked for this injury:_____
Date returned to work after injury:_____ Is an Attorney involved in this case:_____

Have you had surgery for this injury:_____ Type of surgery:_____
Date of surgery:_____ Have you had Physical Therapy within the past year:_____

Are you currently taking any prescription or non-prescription medications? YES or NO
Anti-Inflammatory:_____ Muscle Relaxers:_____ Pain Medications:_____
List Medications or we can copy a list if you already have it:_____
Are you allergic to any medication? Yes or No List Medications:_____
Are you allergic to latex or adhesives? Yes or No

Height:_____ Weight:_____

Have you had any of the following Medical or Rehabilitative Services for this injury/episode? Please mark how many visits you have had for Physical, Occupational and Speech Therapy for this year.

	# Visits				# Visits		
Chiropractor		YES	NO	CT Scan		YES	NO
EMG/NCV		YES	NO	General Practitioners		YES	NO
Massage Therapy		YES	NO	MRI		YES	NO
Myelogram		YES	NO	Neurologist		YES	NO
Occupational Therapy		YES	NO	Orthopedist		YES	NO
Physical Therapy		YES	NO	Podiatrist		YES	NO
Emergency Room Care		YES	NO	X-Ray's		YES	NO
Speech Therapy		YES	NO				

Do you have or you had ANY of the following? PLEASE CIRCLE

Asthma	Bronchitis	Emphysema	Shortness of Breath	Chest Pain	Coronary Heart Disease
Stroke	Numbness	Blood Clot	High Blood Pressure	Anemia	Do you have a pacemaker
Goiter	Epilepsy	Seizures	Heart Attack/Surgery	Gout	Congestive Heart Disease
Diabetes	Tingling	Allergies	Thyroid Disease	Hernia	Arthritis RA OA
Radiation	Chemotherapy	Any Pins	Pregnant	TIA	Osteoporosis
Dizziness	Weight Loss	Elbow Injury	Sleeping Problems	Cancer	Infectious Disease
Fainting	Energy Loss	Hand Injury	Tobacco Use	Vision	Hearing Difficulties
Knee Injury	Metal Implants	Back Injury	Severe Headaches	Varicose Veins	Frequent Headaches
Leg Injury	Foot Injury	Ankle Injury	Shoulder Injury	Neck Injury	Joint Replacement Surgery

Others or Surgerys:_____

List any other information that would assist us in your care:_____

_____

Are you aware of your diagnosis & prognosis as explained by your doctor? YES NO

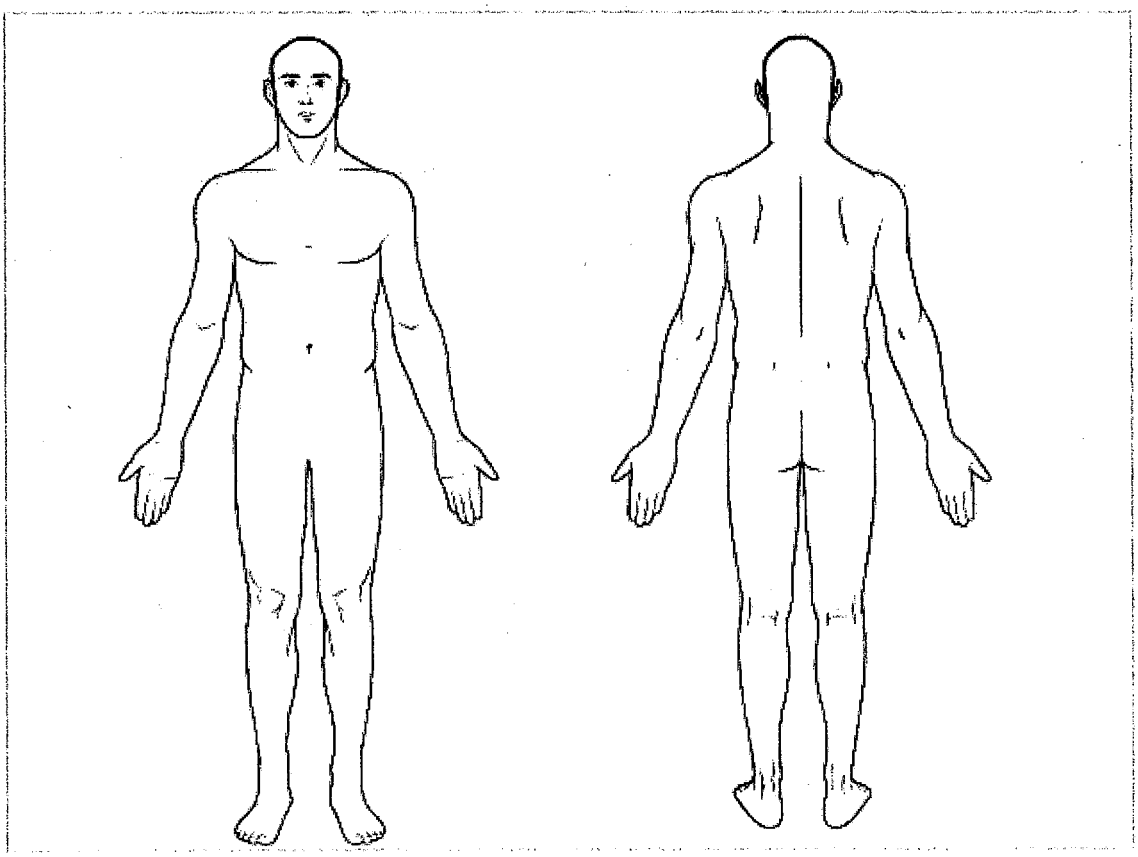
Based on your awareness, what are your rehabilitation expectations/goals while in this Clinic?

_____

Rate your average level of discomfort on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Please map the areas of discomfort or altered sensation on the body chart below.



xxx = pain **ooo = numbness/tingling** **... = weakness**

Patient/Guarding Signature:_____

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below.			Why it matters:
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes(1)	No (0)	Some times I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, espiaically at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed to more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well, or felling slowed down, are linked to falls.
Total_____		Add up the number of points for each "Yes" answer. If you scored **4** points or more, you may be at risk for falling. Discuss this with your Physical Therapist.	

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS INFORMATION CAREFULLY.

1. Your confidential healthcare information may be released to the following:
    a. Other healthcare professionals for the purpose of providing you with quality healthcare.
    b. Your insurance providers for the purpose of receiving payment for providing you with needed healthcare services.
    c. Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic abuse.
    d. Other healthcare providers in the event you need emergency care.
    e. Public health organization or federal organization in the event of a communicable disease or to report a defective device or event to a biological product (food or medication).
2. Your confidential healthcare information may not be released for any other purpose than which is identified in this notice.
3. You may be contacted by Newport Physical Therapy to remind you of any appointments.
4. You have the right to restrict the use of your confidential healthcare information. However Newport Physical Therapy may choose to refuse your restriction if it is a conflict of providing you with quality healthcare or in the event of an emergency situation.
5. You have the right to receive confidential communications about your health status.
6. You have the right to complain to Newport Physical Therapy if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, you may contact Newport Physical Therapy or mail your complaint:

Newport Physical Therapy

1010 SW Coast Hwy, Suite 102

Newport, Oregon 97365

541-265-4252

Signature _____ Date

Newport Physical Therapy

1010 SW Coast Highway, Suite 102
Newport, Oregon 97365

Financial Policy

1. Medical services will be billed to your Insurance Company (limit of two companies): however, we are not acting as an agent for your Insurance Company and we assume no responsibility for collection of any proceeds of Insurance. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged Insurance negotiations, this is your responsibility.

2. Most insurance plans have a Deductible that must be met before the insurance will pay for services rendered. **We will collect $75.00 at the beginning of each visit that will be applied to your Deductible.** When we receive the Explanation of Benefits (EOB) from your insurance, the remaining balance due per visit will be billed to you in the beginning of each month.

3. Many people are under the impression that if they have insurance: it is the Insurance Company that owes the Health Care Provider for the services provided. This is not the case. The Insurance contract is between the patient and the Insurance Company. Therefore, the patient is responsible for the bill, regardless of insurance coverage.

4. The balance of the account is due in full within 60 days of service, unless prior payment arrangements have been made. Delay or denial of payment by your Insurance Company does not relieve you of responsibility for payment.

5. Motor Vehicle or Other Liability Claims : We bill Insurance Companies for such claims; however, settlement of these claims can take many months. A suit against another party is not a reason to delay payment for physical therapy services. We ask that you work with our billing department to make suitable payment arrangements.

6. Delinquent accounts will be referred to a collections agency at the discretion of the Office Manager. If any legal action is initiated by us or by our agents, the undersigned will be responsible for any collection fees including agency and attorney fees and court costs. There is a $25.00 fee for all returned checks.

7. **A 24 HOUR 'BUSINESS DAY' NOTICE IS REQUIRED FOR CANCELLATIONS.**
-FOR EACH CLINIC CANCELLATION, THE FEE IS $40.00
-FOR "NO SHOW" APPOINTMENTS, THE FEE IS $50.00.
-FOR SWIMMING POOL "NO SHOW" FEE IS $50.00.
***IF YOUR INSURANCE COMPANY WILL NOT ALLOW US TO CHARGE YOU FOR MISSING AN APPOINTMENT, YOU WILL BE EXEMPT FROM THE ABOVE FEES.**
****HOWEVER, MULTIPLE SAME DAY CANCELLATIONS OR "NO SHOWING" OF YOUR APPOINTMENT CAN & WILL AFFECT YOUR CARE WITH US, REGARDLESS OF YOUR INSURANCE STATUS. YOU WILL BE DISCHARGED FROM OUR CARE UPON THE SECOND INCIDENT OF CANCELLATION/NO SHOW.**

I understand and agree to the above terms. I authorize the release of any medical information necessary to process my insurance claims and authorize payment of health care benefits to the physical therapist/clinic. I authorize the use of fax machine or other electronic transfer data as required for claim processing.

_____ _____

Signature Date