



Patient Information

Patient Name:	Home Phone:
Street Address:	Work Phone:
PO Box:	Date of Birth:
City, State, Zip:	Email:
Sex: Male Female	Marital Status:
Employer:	Occupation:
Referring Physician:	PCP:

Responsible Party

Person Responsible for Account:	Date of Birth:
Relationship to Patient:	Soc. Sec. #:
Address:	Phone:
City, State, Zip:	
Business Address:	Business Phone:

Are we treating you for an injury that occurred at your place of employment, or due to a motor vehicle accident? Yes No

Primary Insurance:	Secondary Insurance:
Address:	Address:
City, State, Zip:	City, State Zip:
Phone #:	Phone #:
Group/Claim #:	Group/Claim #:
Subscriber ID #:	Subscriber ID #:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Relationship:	Relationship:
Employer:	Employer:

CONSENT TO PHYSICAL THERAPY INTERVENTION: I hereby authorize the healthcare providers of **Impact Physical Therapy of Hillsboro** to administer physical therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that physical 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/occupational therapy is a voluntary healthcare service 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/occupational therapy intervention.

Patient Signature

Date

Parent/Guardian Signature

Date



Name: _____ Date of Birth: _____

Referred by: _____ Primary Care Physician: _____

What is your current condition/injury/surgery? _____

When did this condition begin/injury occur? _____ Surgery date: _____

Previous episodes of similar condition? No: _____ Yes (please specify): _____

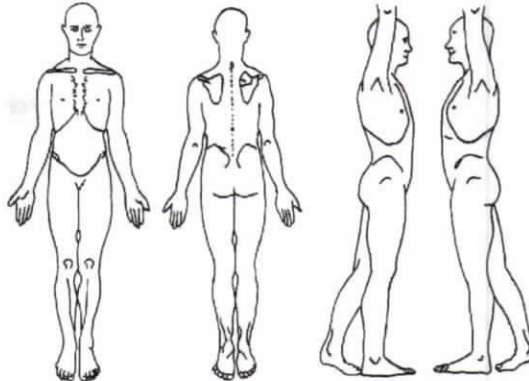
How did your condition begin/injury occur? (please select most applicable):

- | | |
|--|--|
| <input type="checkbox"/> At home injury | <input type="checkbox"/> On the job injury |
| <input type="checkbox"/> Chronic symptoms | <input type="checkbox"/> Repetitive motion injury |
| <input type="checkbox"/> Unknown/insidious onset | <input type="checkbox"/> Sports or recreational injury |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Trauma |

How quickly did the condition develop? Suddenly: _____ Gradually: _____ Unknown: _____

Since the onset, are your symptoms: Improving: _____ Not Changing: _____ Worsening: _____

Please use the body charts below to shade the area(s) where you feel pain:



How frequently does the pain occur during your day? Constantly: _____ Intermittently: _____

What does your pain/symptoms feel like (check all that apply):

- | | | |
|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Achy | <input type="checkbox"/> Pulsing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting |

Please give 2 or more specific positions or activities that make your symptoms worse:

Please give 2 or more specific positions or activities that make your symptoms better:

Is your pain better or worse at a certain time of day?

AM: _____

PM: _____



Does your current condition affect your sleep? No: _____ Yes: _____ If yes:
Does your condition make it difficult to fall asleep? No: _____ Yes: _____
Does your condition wake you up from asleep? No: _____ Yes: _____

Do you experience any of these additional symptoms?

- | | | |
|--|--|--|
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Bowel/bladder changes | <input type="checkbox"/> Weakness | <input type="checkbox"/> Speaking problems |
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Weight changes | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vision problems | |

Pain Scale: for each of the following, please circle the number that best represents your pain:

Your **present** pain level:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Your **worst** pain level in the last **48 hours**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Medical History:

At the present time, would you say your overall health is: Excellent Good Fair Poor

Please check all of the below condition(s) you have ever had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Head injury | |

Are you pregnant? Yes: _____ No: _____

Have you had a fall or "near fall" in the past 6 months? Yes: _____ No: _____

If yes, please explain: _____

Please list the prescribed medications & their dosages you are taking (or provide a written copy):

Surgical History: _____

Please circle "Yes" or "No" for the following questions:

- | | | |
|---|-----|----|
| 1. Do you currently have any infections? | Yes | No |
| 2. Do you currently have <u>uncontrolled</u> high blood pressure? | Yes | No |
| 3. Do you tend to bruise easily? | Yes | No |
| 4. Have you ever had blood clots and/or inflamed veins? | Yes | No |
| 5. Do you tend to bleed for a long time after injury? | Yes | No |

I will advise the physical therapist of any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature: _____

Date: _____

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 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by KAB Physical Therapy LLC DBA: Impact Physical Therapy of Hillsboro (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.
2. 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.
3. 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: Impact Physical Therapy of Hillsboro Attention: Compliance Officer 4950 NE Belknap Court Hillsboro, OR 97124. 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 except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

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

Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

Signature of Authorized Practice Representative

Date

Effective Date: 1/1/11

PATIENT PRIVACY POLICY

WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH A DETAILED WRITTEN NOTICE DESCRIBING HOW THIS CLINIC MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN OBTAIN OR CORRECT THIS INFORMATION.

- ❖ We may use your medical information or disclose it to others in order to provide or arrange for your health care, to arrange payment or reimbursement for the care that we provide to you, or to carry out administrative activities related to or supporting your treatment.
- ❖ We may be required or permitted by certain state or federal laws, regulations, or legal circumstances to use or disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.
- ❖ As our patient, you have important rights regarding your medical information in this clinic. You have the right to inspect, copy, amend or correct that information, obtain an accounting of disclosures of your medical information, request that we communicate with you confidentially and request that we restrict certain uses and disclosures of your health information. We have a procedure for filing a complaint if you think your rights have been violated.
- ❖ We will provide a detailed NOTICE OF PRIVACY PRACTICES to you which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect. You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask the front desk and we will provide you with a copy.
- ❖ If you have any questions, concerns or complaints about the NOTICE, please contact Anna Bond at (503) 615-5969.

NOTICE OF PATIENTS' RIGHTS

AS A PATIENT, YOU HAVE THE RIGHT TO:

- ❖ Participate in the development and implementation of your plan of care.
- ❖ Make decisions regarding your care.
- ❖ Have your personal privacy respected.
- ❖ Receive care in a safe setting, free from verbal abuse or harassment.
- ❖ Refuse any or all treatment.

SCHEDULING APPOINTMENTS

Impact Physical Therapy of Hillsboro will make every attempt to set appointments outside of the patient's work hours. However, it is impossible to do so in every case. If you have a scheduling preference, please let us know and we will attempt to accommodate your needs.

Anyone missing two or more sessions for any reason may be subject to treatment termination at the therapist's discretion. (Missed appointments are no shows or same day cancellations).

WORKERS' COMPENSATION PATIENTS

Continued missed appointments may affect Workers' Compensation Benefits under OAR 436-060-0105(1). The insurance carriers and physicians will receive a copy of the progress records, which include attendance records.