PHYSICAL THERAPY OF BANKS
IMPACT

Patient Information

Patient Name:	Cell Phone:
Street Address:	Home Phone:
PO Box:	Date of Birth:
City, State, Zip:	Email:
Sex:	Emergency Contact:
Employer:	Emergency Contact Phone:
Referring Physician:	PCP:

Responsible Party

Person Responsible for Account:	Date of Birth:
Relationship to Patient:	Social Security #:
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?

MVA_____ WC_____ N/A_____

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 Banks to administer physical therapy interventions and procedures, as they deem professionally and clinically necesssary. 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 as well as Telehealth visits or E-visits. 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 physical/occupation therapy Intervention.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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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 sleep? No: _____ Yes: _____

Do you experience any of these additional symptoms?

- ☐ Numbness/ Tingling
- ☐ Bowel/ Bladder Changes
- ☐ Fever/ Chills
- ☐ Dizziness/ Fainting
- ☐ Loss of Balance
- ☐ Coordination Problems
- ☐ Weakness
- ☐ Weight Changes
- ☐ Night Sweats
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Speaking Problems
- ☐ Swallowing Problems
- ☐ Other: _____

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:

- ☐ Osteoarthritis
- ☐ Broken Bones/ Fractures
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Coordination Problems
- ☐ Lung Problems
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Stroke
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Other: _____

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 & the dosage 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 uncontrolled 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 an injury? Yes No

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

Patient (or Guardian) Signature: _____ Date: _____

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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: _____

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

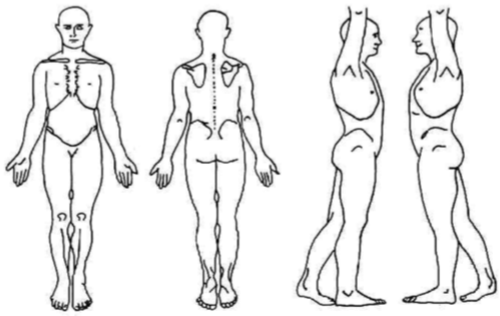
- ☐ At Home Injury
- ☐ Chronic Symptoms
- ☐ Unknown/ Insidious Onset
- ☐ Motor Vehicle Accident (MVA)
- ☐ On the Job Injury
- ☐ Repetitive Motion Injury
- ☐ Sports or Recreational Injury
- ☐ Trauma

What state did MVA occur? _____

How quickly did symptoms 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):

- ☐ Dull
- ☐ Sharp
- ☐ Achy
- ☐ Throbbing
- ☐ Pulsing
- ☐ 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:

_____

_____

_____

Which time(s) of day are your symptoms the worst: Morning Afternoon Evening Night

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 (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 and all treatment.

SCHEDULING APPOINTMENTS

Impact Physical Therapy of Banks 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.

Effective Date: 1/1/11

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©(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 at KAB Physical Therapy LLC DBA: Impact Physical Therapy of Banks (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 places 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 HEALTHCARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient's Name Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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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

PHYSICAL THERAPY OF BANKS
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PAYMENT POLICY

Patient: _____ Date of First Visit: _____

Is your injury work related? **Yes or No** If yes, list Employer:_____ Date of Injury: _____
Were you injured in a motor vehicle accident? **Yes or No** If yes, list the state where the accident occurred: _____

For patients with a deductible or who are paying "out of pocket," we offer the flexibility of paying a portion of your balance at each visit. In addition, we can set up a monthly payment plan at the beginning of care to avoid creating a large balance due.

Assignment of Benefits: I hereby assign to KAB Physical Therapy LLC DBA: Impact Physical Therapy of Banks all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program and I direct that all benefits be paid directly to Impact Physical Therapy of Banks. Do not keep insurance checks which are issued in payment of service rendered by this practice. No payment plan will be allowed for patients who keep insurance checks and the balance will be due immediately.

We offer a cash pay price if you do not have insurance. The discounted price will be due at the time of service.

Note: Account balances must be paid in full within three months of the date of your first visit. If you do not pay your bill or set up a payment plan you will be sent to collections. As a small business we are not set- up to extend credit.

We require 24 hours' notice if you cannot make your scheduled appointment. If you are unable to make your appointment due to an emergency, we will understand. All **NO SHOWS & CANCELLATIONS** are subject to a $50 fee. All **NO SHOWS** over two are subject to notification sent to your insurance carrier, case worker and/ or referring physician. All **NO SHOWS** over three are subject to dismissal from treatment and you will be referred to your physician. Payment for **NO SHOWS or CANCELLED** appointments without notice are due at the next date of service.

Impact Physical Therapy of Banks provides the courtesy of calling your insurance company for eligibility and benefits. **This does not guarantee that the information we are given is up-to-date or accurate, nor does it guarantee payment from your insurance company. You are responsible for balances that your insurance company does not cover.**

I understand the Payment Policy of Impact Physical Therapy of Banks and I have received a copy of the Notice of Patient's Rights.

_____ _____
Patient (or Guardian) Date

Please complete the Payment Arrangement below:

- ☐ I agree to pay a copay of $_____ at each visit.
- ☐ I agree to pay the balance of monthly statement.
- ☐ I agree to pay $_____ monthly and/ or $_____ per visit to go towards account balance/ deductible.
- ☐ I agree to pay at the time of service due to not billing insurance.
- ☐ I agree to pay my deductible of $_____ and my coinsurance of _____%.

_____ _____
Patient (or Guardian) Date