



Patient Information

| | |
|--|-----------------|
| Patient Name: | Home Phone: |
| Street Address: | Work Phone: |
| PO Box: | Date of Birth: |
| City, State, Zip: | Soc. Sec. #: |
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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: |

| 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: |

Emergency Contact Information

| | |
|-------------------|---------------|
| Name: | Relationship: |
| Address: | Phone: |
| City, State, Zip: | |

CONSENT TO PHYSICAL THERAPY INTERVENTION: I hereby authorize the healthcare providers of **Impact Physical Therapy, LLC** to administer physical therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that physical therapy interventions may 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 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 therapy intervention.

Patient Signature

Date

Parent/Guardian Signature

Date



MEDICAL HISTORY

Name: _____ Phone: _____

Age: _____ Date of Birth: _____

Referred by: _____

Primary Care Physician (if different from above): _____

Employment: Full Time Part Time Unemployed Retired Student Disabled

Dominant Hand: Right Left

Prescription medications with dosage: (required) _____

Surgical History: _____

Have you received physical therapy treatment this calendar year? Yes No

Medical History (check all that you have ever had)

- | | |
|---|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Lung Problems | Other: _____ |
| <input type="checkbox"/> Osteoporosis | _____ |

Are you pregnant? Yes No

What is your current condition/injury? _____

Is this condition due to: Work injury Auto accident?

When did the current problem(s) begin/injury occur? _____ Surgery date: _____

I have difficulty with: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Household chores | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Standing | <input type="checkbox"/> Work duties |
| <input type="checkbox"/> Bathing/dressing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Recreational activities: _____ |

Are you having any of these symptoms? (Check all that apply)

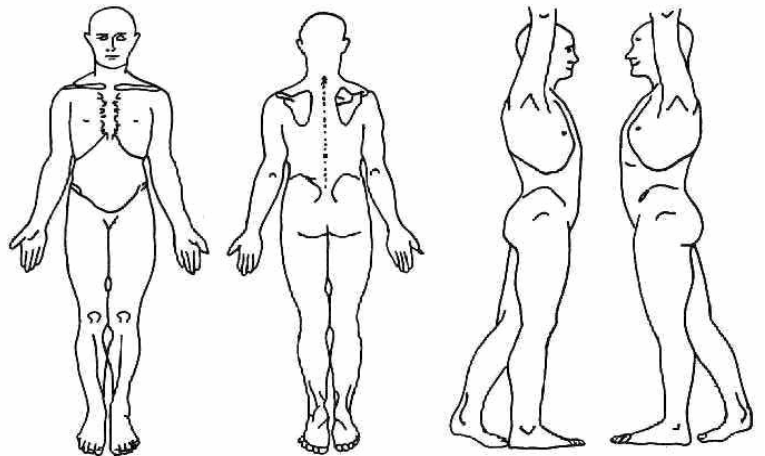
- | | |
|--|--|
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness |

(Continued on next page)

- Do you currently have any infections? Yes No
- Do you currently have uncontrolled high blood pressure? Yes No
- Do you tend to bruise easily? Yes No
- Are you taking blood thinner medication? Yes No
- Do you take aspirin on a daily basis? Yes No
- Do you regularly take cortisone? Yes No
- Have you ever had blood clots and/or inflamed veins? Yes No
- Do you have surgical implants? Yes No
- Do you have diabetes and/or kidney disease? Yes No
- Do you tend to bleed for a long time after an injury? Yes No

Body Chart

Use the body charts on the right to shade the area(s) where you feel pain.



Pain Scales

On each of the scales shown below, please circle the number which best represents the severity of your pain at the time noted.

The **least** level of pain you have experienced during the last 48 hours:

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

The **worst** level of pain you have experienced during the last 48 hours:

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

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

Patient Signature: _____

Date: _____



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 report of pain taken seriously and to be treated with dignity and respect.

Have your personal privacy respected.

Receive care in a safe setting, free from verbal abuse or harassment.

Confidentiality of your clinical records and the right to access information contained in your clinical records within a reasonable time frame (except in certain circumstances specified by law).

Refuse any or all treatment.

SCHEDULING APPOINTMENTS

Impact Physical Therapy, LLC 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: April 14, 2003

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.

Here is a brief summary:

- ❖ 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 or your medical information, please contact Carie Campos of our office at (541) 476-1919.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Impact Physical Therapy, LLC (referred to below as “the clinic”) will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **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 health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to/or consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care, including provision of medical supplies and equipment, and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgment
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please specify)
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