Welcome! *Summit Physical Therapy, Inc.*

6464 SW Borland Road, Suite B5 Tualatin, OR 97062 503-699-2955

NAME_____ TODAY'S DATE_____
Last (Please print) First MI

EMAIL ADDRESS:_____

HOME ADDRESS_____

CITY_____ ST_____ZIP_____

HOME PH#_____ CELL PHONE:_____

SEX ☐ M ☐ F AGE_____ BIRTHDATE_____ / _____ /_____ REFERRING DOCTOR _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED PRIMARY CARE DOCTOR_____

IS PATIENT A MINOR? ☐ NO ☐ YES. IF SO, RESPONSIBLE PARTY_____

RESPONSIBLE PARTY BIRTHDATE:_____ /_____ /_____ RELATIONSHIP TO PATIENT_____

YOUR EMPLOYER NAME_____ OCCUPATION_____

****

PRIMARY INSURANCE CO_____ PH#_____

POLICY ID#_____ GROUP#_____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S DOB_____ /_____ /_____

SECONDARY INSURANCE CO_____ PH#_____

POLICY ID#_____ GROUP#_____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S DOB_____ /_____ /_____

****

IS THIS INJURY BEING COVERED BY AN OPEN WORK COMP CLAIM? ☐ NO ☐ YES
IS THIS INJURY BEING COVERED BY AN OPEN AUTO ACCIDENT CLAIM? ☐ NO ☐ YES

IF YES TO EITHER, DATE OF INJURY _____ /_____ /_____ INSURANCE CO_____

CLAIM#_____ ADJUSTER NAME_____

ADJUSTER PH#_____ ADJUSTER FAX#_____

INSURANCE COMPANY ADDRESS_____

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How did you hear about us?

☐ SUMMIT P.T. WAS RECOMMENDED BY DR._____ ☐ REFERRED BY FRIEND/FAMILY

☐ I AM A FORMER PATIENT ☐ SUMMIT P.T. IN NETWORK PROVIDER LIST ☐ WEBSITE/ONLINE SEARCH

☐ WORD OF MOUTH ☐ SIGN/DROVE BY

ASSIGNMENT & RELEASE OF BENEFITS:

I hereby assign all benefits from the above named insurance(s) to be paid directly to Summit Physical Therapy for services rendered. I authorize the use of my signature on all insurance submissions. Summit Physical Therapy may use my healthcare information and may disclose such information to the above named insurance company (ies) for the purpose of obtaining payment and for determining insurance benefits or the benefits payable for related services.

_____ _____
SIGNATURE PRINTED NAME

SUMMIT PHYSICAL THERAPY

PATIENT INTAKE FORM

Name _____ Date_____

Height _____ Weight _____ Occupation_____

Referring Physician_____

1. Please describe in detail the condition we are seeing you for:

_____

_____

_____

2. Date of onset: _____ Surgery Date (if applicable):_____

3. Do you have (circle all that apply): pain numbness tingling weakness

4. Are your symptoms (circle one): continuous intermittent

5. Are your symptoms (circle one): getting better staying the same getting worse

6. Please mark on the line to indicate how severe your pain was:

At its worst (write "W") and as it is today (write "T")

NO PAIN [0 ---------- 5 ---------- 10] PAIN AS BAD AS IT CAN GET

7. Do symptoms awaken you at night? (circle one) yes no

8. What time of day is it worse?_____

9. What makes your symptoms worse?_____

10. What makes your symptoms better?_____

11. What previous tests/treatments have you received for the condition? (MRI, x-ray, physical therapy, chiropractic)_____

12. Please indicate any of the following you have seen in the past months and describe the reasons:

Medical/Doctor:_____

Osteopath:_____

Physical Therapist:_____

13. Please list any other diagnosed medical problems: Heart Disease, cancer, Diabetes, hepatitis, etc)

_____

_____

_____

14. Have you experienced any of the following? (circle all that apply)

Weakness Weight gain Weight loss Numbness Tingling Fatigue Fever/sweats

15. Please list all previous injuries and surgeries with approximate dates:

_____

_____

_____

16. List all medications you have taken recently (prescription and non-prescription):

_____

_____

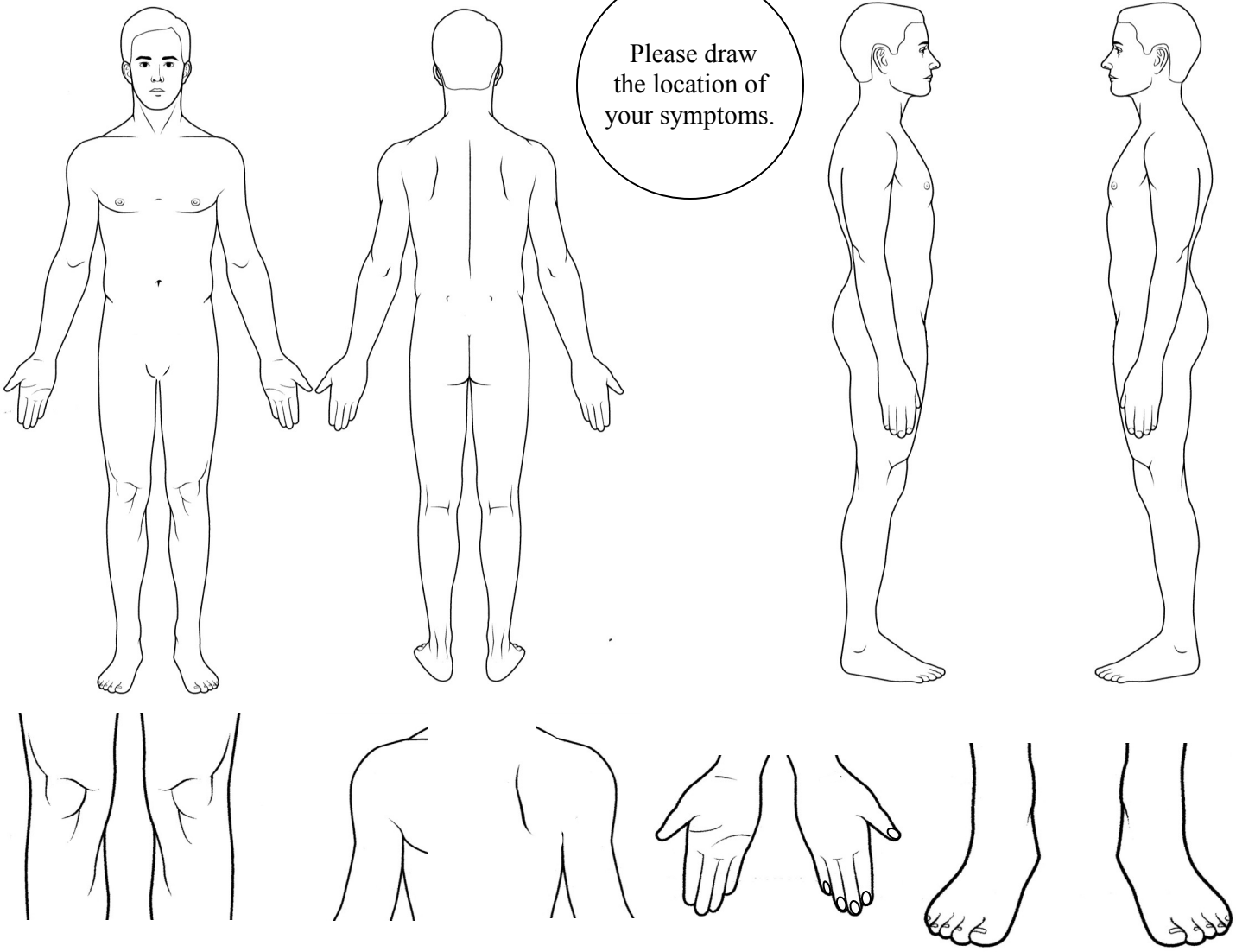
_____

17. When is your next doctor's appointment? _____

18. How is your general health? (circle one) Excellent Good Fair Poor

19. Are you currently exercising? (circle one) Yes No

Please draw the location of your symptoms.



SUMMIT PHYSICAL THERAPY
Policies & Procedures

****Please initial beside each section, and sign and date below.****

____ Cancellations:

Three people are affected when you miss an appointment without notice. You don't get treated, another patient misses an opportunity to be seen, and the therapist has a gap in his schedule. Our 24-hour voicemail can take your cancellation call at any time, even when the office is closed. ***Please give us a timely notice, preferably 24 hours in advance. Short cancellations and no-shows will incur a $35.00 charge.***

_____ Co-pays & Deductible:

Insurance co-pays are due at the time of service. If you have an insurance deductible due, you will be asked to pay a minimum of $50.00 towards that amount at the time of service. Any additional balance will be billed to you after the insurance has completed their processing. We have a returned-check fee of $25.00.

_____ Financial Responsibility:

We bill your insurance as a courtesy, and will work with the insurance to resolve any denied claims or problems. ***However, ultimate responsibility for payment of services rests with the patient.*** We are always happy to work with you on payment plans during times of financial hardship, but accounts that become past due without any effort towards payment will be assigned to an outside collection agency, which may adversely affect your credit rating.

_____ Privacy:

Summit Physical Therapy is committed to maintaining your privacy and protecting your personal health information. Your signature below indicates your acknowledgement that you have received a copy of our Patient Privacy Policy.

_____ Release of Information:

Your signature below authorizes us to exchange any information necessary for your treatment with other medical providers involved in your care, including but not limited to history obtained, x-ray and physical findings, diagnosis and prognosis, and record of current treatment plan.

****

_____ _____

Signature Date

_____ _____

Printed Name Relationship to patient (if other than self)

Summit Physical Therapy
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 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 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 at 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 Paul Kane of our office at (503) 699-2955.