PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:____ AGE:________ GENDER: ❑ Female ❑ Male

OCCUPATION:____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all………Mildly optimistic…………Fairly…………Very optimistic……..Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		

Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):____ Date: ________

INTAKE FORM

Date:____________

Patient Full Name____ Date of Birth _____________ Age:______ Sex: M F

Address: ____ City/State/Zip:____

Cell Phone: ____ Email Address:____

Emergency Contact Person & Phone:____

Primary Physician:_____________________________________ City/State:__________________________________ Phone #:_______________________

If patient is a MINOR, parent/guardian's name and signature here: ____

FITNESS Goals: ❑ Lose Weight ❑ Body Toning ❑ Other: ____

STRESS Level : 1 low----2----3----4----5 high What's the main cause? ______________________________________

NUTRITION: What is your level of nutrition knowledge? ❑ None ❑ A little ❑ Medium ❑ A Lot

SUPPORT STRUCTURE: Who do you have nearby that is close to you? ❑ Family ❑ Friend(s) ❑ None ❑ Other: ________

Name something that is really important to you (or really enjoy doing)? ____

PERSONALITY TYPE: ❑ Social ❑ Emotional ❑ Intellectual ❑ Physical

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How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Facebook ❑ Advertisement ❑ Other: _______________

IMPORTANT RULES & POLICIES

1. Late Policy: If I'm late more than 10-minutes to my appointment, I may be rescheduled or asked to wait for next available open time slot.
2. 48-Hour advance notice is required for changes to my appointment otherwise a $25 fee may apply.
3. Co-pays and/or deductibles are due prior to treatment starts.
4. Not showing for an appointment without notice (or less than 48-hours in advance) will result in a $25 fee added to my account.
5. Cell phones must be shut OFF or silent.
6. Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.
7. If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.
8. If for any reason you are NOT satisfied with the care received, please call our administrator at 541-660-1242.

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Siskiyou PT and the physical/occupational therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Siskiyou PT, and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Siskiyou PT, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Siskiyou PT and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Siskiyou PT.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE SISKIYOU PT FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: ____ Signature____ Date:__________

INSURANCE ASSIGNMENT OF BENEFITS

Patient Full Name____ ❑ Single ❑ Married

Referring Physician:________________________________ PH______________ FAX____________

Street Address________________________________ City/State:__________________ Zip______

Work status: ❑ Currently Employed ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T or __F/T)

POLICY #1:

Plan Benefit Verification: ❑ Deductible $______ ❑ Coinsurance $______ ❑ Co-pay $____ ❑ Maximums:____________

Policy Name:________________________ Policy#__________________ Group# (if applicable)__________

Policy Holder Name (If other than patient):________________________________ DOB________ SSN__________

Address (if different than patient):____

Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:______________________________

Employer____ PH________________ Claim#________

Employer address.____

POLICY #2 (if applicable)

Plan Benefit Verification: ❑ Deductible $______ ❑ Coinsurance $______ ❑ Co-pay $____ ❑ Maximums:____________

Policy Name:________________________ Policy#__________________ Group# (if applicable)__________

Policy Holder Name (If other than patient):________________________________ DOB________ SSN__________

Declaration to Insurance Company

I hereby instruct and direct ________________________________ insurance company to pay by check made out to the "Healthcare Provider" named below and mailed to the address below. If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the "Healthcare Provider" for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Conditions Required in Order for "Healthcare Provider" to Accept This Assignment

If any boxes are left unchecked, clinic reserves the right to refuse this assignment and patient must pay out-of-pocket for services.

- ☐ A photo copy of this assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance claims.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.
- ☐ This is a direct assignment of my rights and benefits under this policy.

DATE: _________/________/20_______

Signature of Patient/Claimant____

(If applicable) Signature of Policy Holder if not same as patient______________________________

HIPAA Notice Acknowledgement & Consent

Siskiyou Physical Therapy

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office **Siskiyou Physical Therapy** and understand my rights contained in the notice.

____ _________
Signature of PATIENT or LEGAL GUARDIAN Date

______________________________ ______________________________
Print Name of Patient Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for **Siskiyou Physical Therapy** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Siskiyou Physical Therapy** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Siskiyou Physical Therapy Attn: Kendra Laratta PO BOX 2630, Grants Pass, OR 97528**.

With this consent, **Siskiyou Physical Therapy** may:

- ☐ Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- ☐ Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked “Personal and Confidential.”
- ☐ Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- ☐ E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that **Siskiyou Physical Therapy** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Siskiyou Physical Therapy** to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Siskiyou Physical Therapy** may decline to provide treatment to me.

____ _________
Signature of PATIENT or LEGAL GUARDIAN Date

______________________________ ______________________________
Print Name of Patient Print Name of Legal Guardian, if applicable

SISKIYOU PT

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (541) 479-6936. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (541) 479-6936. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201