STEP & SPINE
PHYSICAL THERAPY

PATIENT REGISTRATION

CHART # _____

Date _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Mailing Address _____
STREET/PO BOX CITY STATE ZIP

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Gender: ☐ M ☐ F

Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Name _____ Phone _____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Student

Employer _____ Occupation _____

Employer Address _____

Referring Doctor _____ Primary Care Doctor _____

How did you hear about us? _____

_____ Private Insurance _____Self Pay _____ Workers comp. _____ Motor Vehicle Accident

Workers Comp: Company Name _____ Phone # _____

Date of Injury _____ Claim #_____

Motor Vehicle Accident: Insurance Name _____ Phone # _____

Date of Injury _____ Claim # _____

PATIENT REGISTRATION PART II

Payment Agreement

_____ (initial) I understand that prompt payment for all therapy services is my responsibility regardless of the insurance or other third party coverage.

A monthly statement will be sent to you. We accept payment by cash, check, money order, or credit card. Past due accounts, **over 90** days, will be subject to a monthly rebilling charge. Legal procedures for collection of past due accounts will be **initiated** if non-payment of account extends beyond **150 days**. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. It is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance on your account, your money will be promptly refunded to you or your insurance company.

For claims in pending litigation (or dispute as to the responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made or if the balance becomes untenable.

Medicare – we accept Medicare assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

I authorize payment of medical benefits to Step & Spine Physical Therapy, LLC, and I have read and understand this payment agreement.

Consent to Treat and Authorization to Release Information

_____ (initial) I voluntarily consent to *evaluation and treatment* by Step & Spine Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the *release of information* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

_____ (initial) I authorize *phone messages* regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

_____ (initial) A copy of this facility's *Statement of Privacy Notice* has been provided to me.

"No Show" Policy

_____ (initial) Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a "no-show." A no-show patient is charged a fee, as set by Step & Spine Physical Therapy, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from Step & Spine Physical Therapy.

Authorization and Release of Testimonials and Quotes

_____ (initial) I hereby give authorization to Step & Spine Physical Therapy, LLC to use my testimonials and quotes for use on the Step & Spine Physical Therapy web site, blog, newsletter, advertising and correspondence.

By signing below, I certify that I have read the *Payment Agreement*, *Consent to Treat and Authorization to Release Information*, and *"No Show" Policy* sections above and agree to all statements contained therein.

Patient's Signature _____ Date _____

Signature of Responsible Party _____ Relationship _____ Date _____

PATIENT HISTORY

CHART # _____

Date _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: □Employed □ Employed with restrictions □ On medical leave □ Not employed

I currently: □ Live alone □ Live with caregiver □ Live with family members

Current living environment: □ Home/apartment □ Retirement home □ Assisted living

Do you smoke? □ Yes □ No Packs per day _____ Do you drink alcohol? □ Yes □ No Drinks per week _____

Do you exercise? □ Yes □ No Type _____ Times per week _____

Interests/hobbies/exercise _____

Will you have any problems attending therapy sessions? □ Yes □ No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

□ Allergies □ Arthritis/Gout □ Blood Disorder □ Cancer □ Circulation/Vascular Problems

□ Heart Disease □ Depression □ Diabetes □ Epilepsy/Seizures □ Fibromyalgia

□ Head Injury □ Hearing Problems □ High Cholesterol/Lipids □ Recent Hospitalization □ Hypertension

□ Infectious Disease □ Kidney Disease □ Liver Disease □ Lung Disease □ Migraines

□ Multiple Sclerosis □ Osteoporosis □ Pacemaker □ Panic Attacks/Anxiety □ Parkinson's disease

□ Stomach Disease/ Ulcer/Reflux □ Stroke/Paralysis □ Thyroid Disease □ Visual Problems

□ Surgery – type(s) _____

If female, are you currently pregnant? □ Yes □ No

Are you taking any medications? □ Yes □ No If yes, please list _____

_____

Have you had any prior treatments for your current condition (check all that apply)?

□ Hospitalization □ Bracing/Taping/Casting □ Physical Therapy □ Surgery □ TENS/Stimulation Unit

□ Injections □ Chiropractic □ Acupuncture □ Other _____

Are you having trouble sleeping? □ Yes □ No Normal hours of sleep: _____hours Current hours of sleep: _____hours

PATIENT HISTORY PART II

PREVIOUS FUNCTIONAL LEVEL

Before the onset of my current symptoms (or prior to injury), I was: ☐ Independent in all activities ☐ Dependent for all care

☐ Independent with self-care only ☐ Needing assistance with some activities ☐ Needing assistance with most activities

PERSONAL GOALS FOR THERAPY

What do you want to achieve from having therapy? ☐ Reduce Pain ☐ Increase Function ☐ Return to Work

☐ Return to usual housework/yard work ☐ Return to recreation, types _____

☐ Sleep without waking up ☐ Other _____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your MAIN complaint? _____

_____

Please mark your level of pain with an **X** along the following lines:

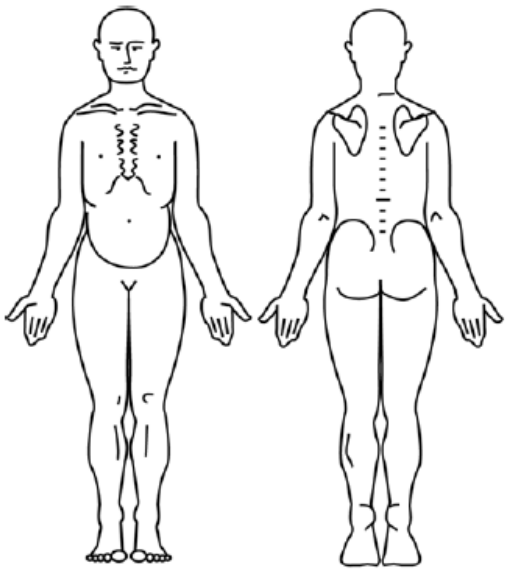
What is your level of pain at rest?

No Pain — *Worst Pain Imaginable*

What is your pain with activity?

No Pain — *Worst Pain Imaginable*

Darken the areas on the body where you are having problems:



How would you describe your pain (check all that apply)?

☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Discomfort ☐ Dull

☐ Gnawing ☐ Loss of Sensation ☐ Numbness ☐ Pressure ☐ Sharp

☐ Stabbing ☐ Stinging ☐ Swollen ☐ Throbbing ☐Tight ☐ Tingling ☐ Weakness ☐ Other _____

When and how did these symptoms begin? _____

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

Since the onset of your symptoms have you had any of the following (check all that apply)? ☐ Significant, unexplained weight loss

☐ Atypical night pains ☐ Impaired bowel/bladder function ☐ Pain in multiple areas ☐ Dizziness/fainting ☐ Muscle weakness

☐ Fever/chills ☐ Numbness ☐ Visual/Hearing Problems

PATIENT PRIVACY NOTICE

We are required by law to give you this notice. It describes how medical information about you may be used and disclosed, and how you can get access to this information.

Please review this information carefully.

- I understand that my protected health information may include information both created and received by the clinic, may be in the form of written, 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 types of health-related information.
- Your protected health information may be released to your insurance provider in order to obtain prior approval or to determine whether your plan will pay for the treatment.
- Your protected health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your protected health information may be disclosed for public health reasons in order to prevent or control disease, injury or disability.
- Your protected health information may be disclosed if you are involved in a lawsuit or dispute, through a court or administrative order or in response to a subpoena.
- Your protected health information may be released only after receiving written authorization from you with the exception of those listed above or for treatment, payment, or healthcare operations. Other uses and disclosure that require a written authorization from you include Marketing and Fundraising. You may revoke your permission to release protected health information at any time. It must be in writing with effective date and be specific to the health information being protected. Step & Spine Physical Therapy is not required to agree to your request.
- You may be contacted by Step & Spine Physical Therapy by phone or mail (or leave a message on an automated answering device) to remind you of appointments, verify insurance/demographic information, etc. You have the right to request a more confidential way of providing your protected health information or alternative communication method at the time you are seen at Step & Spine Physical Therapy.
- You have the right to restrict the use of your protected health information. However, Step & Spine Physical Therapy may choose to refuse your restriction if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- We may disclose health information about a minor child equally to the custodial and non-custodial parent unless a court order limits the non-custodial parent's access to the information.
- You have the right to review and photocopy any or all portions of your health information. Step & Spine Physical Therapy has the right to assess a fee for the photocopying of the health information.
- You have the right to request an amendment to your health information. It must be in writing and explain why the information should be amended. Step & Spine Physical Therapy can deny the amendment if your request is not in writing, does not include a reason to support the request, or is information that we did not create. A written explanation will be provided if we deny your request.
- Step & Spine Physical Therapy is required by law to protect the privacy of its patients. It will keep protected any and all patient health information.
- Step & Spine Physical Therapy will abide by the terms of this notice. Step & Spine Physical Therapy reserves the right to make changes to this notice and will continue to maintain the confidentiality of all health information. Changes to this notice will be redistributed at your next visit to Step & Spine Physical Therapy.
- You have the right to complain to Step & Spine Physical Therapy, if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your written complaint to: Step & Spine Physical Therapy, P.O. Box 1510, Sisters, OR 97759
- All complaints will be investigated. No personal issue will be raised by filing a complaint with Step & Spine Physical Therapy.
- You may also file a complaint to: Region IV, Office of Civil Rights, US Dept. of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303-8909

If you would like more information regarding this Privacy Notice, please contact our office at 541-588-6848.