CONSENT FOR TREATMENT

FOCUS PHYSICAL THERAPY

I, the undersigned, voluntarily consent to the use or disclosure of my protected health information by Focus Physical Therapy, Inc. for the express purpose of providing treatment, obtaining payment for my health care costs or to conduct health care operations. I understand that treatment may be conditional upon my consent.

I understand that I have the right to request a restriction as to how my protected health information is utilized or disclosed in order to carry out treatment, receive payment or other health care operations of the clinic. Focus is not obligated to agree to my stated restrictions. I understand that should Focus agree to my stated restrictions that it will be binding on Focus and my physical therapist. I have the right to revoke this consent in writing, at any time, except to the extent that my physical therapist and Focus have taken action in reliance on this consent.

My protected health information consists of any health information, including my demographic information, collected from me and created or received by my physical therapist, other health care providers, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present or future physical or mental health or any other condition that identifies me, or when there is a reasonable basis to believe the information may identify me.

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I have personally received a copy of the Notice of Privacy Practices prior to signing this Consent for Treatment. This notice describes the variety of uses and disclosures of my protected health information that may occur during my treatment with Focus. The notice also outlines my rights and responsibilities with respect to my protected health information. I understand that Focus has the right to alter their Notice of Privacy Practices at any time. When changes are made to the policy, Focus will notify me in writing upon my next visit.

I hereby authorize Focus to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance directly to me and that I am personally responsible for the payment.

I hereby authorize the insurance company/insurance administrator to pay by check or electronic funds transfer (EFT) and for it to be mailed directly to Focus the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner, any balance of professional charges.

I direct my attorney to pay any outstanding expenses from my settlement, and in effect, protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the physical therapist's additional protection and consideration for his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover. I have been advised that if my attorney does not wish to cooperate in protecting this physical therapist's interest, the physical therapist will not await payment, but require me to make payment on a current basis.

I authorize Focus to administer care as deemed appropriate and necessary to my dependent minor named:

_____

_____ _____

Signature of Patient or Responsible Party **Date**

New Patient Registration Form

Please give your insurance card(s) to the receptionist for copying. Thank you.

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Name: _____ Date: _____
First MI Last

Home address: _____
Street City State Zip code

Mailing address: _____
(if different from above) Street City State Zip code

Home phone: (w/area code) _____ Cell phone: _____

Work phone: _____ Email: _____

Employer: _____ Occupation: _____ **Date of Birth:** _____

Gender: ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Emergency Contact: _____ Phone Number: _____

Primary Care Physician: _____ Appt. Reminder via: ❑ Email ❑ Phone ❑ No Reminder

Referring Physician: _____ Date of Next Appointment: _____

INSURANCE

PRIMARY Insurance: _____ **Insured's Name:** _____ **Insured's DOB:** _____

Insured address (if different from above): _____

Policy ID#: _____ **Group #:** _____

SECONDARY Insurance: _____ **Insured's Name:** _____ **Insured's DOB:** _____

Insured address (if different from above): _____

Policy ID#: _____ **Group #:** _____

Motor Vehicle Accident or Workers' Comp Patients ONLY

Date of accident: ❑ Work ❑ Auto—please specify location of accident, if other than Oregon: _____

Employer name and phone: _____ Soc Sec #: _____

Employer address: _____ **Claim #:** _____

Name of Insurance co. (workers' comp or auto PIP) _____

Insurance co. address: _____

Adjuster name: _____ Adjuster phone: _____

Name of insured: _____ Name of lawyer and phone: _____

Please tell us how you learned of our services or whom we can thank:

❑ Former patient ❑ Doctor recommendation ❑ Insurance company recommendation
❑ Former patient recommended you (name) _____
❑ Family/friend recommended you (name) _____

❑ Are you currently enrolled in Hospice, Home Health or Inpatient Physical Therapy?

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services.

✘ SIGNATURE: _____ **DATE:** _____

❑ **check here if you would like to receive info/updates/class information via email from us.**
We do not share email addresses with anyone under any circumstances).

FOCUS
PHYSICAL THERAPY

SHORT-NOTICE CANCELLATION AND MISSED-APPOINTMENT POLICY

Your time is precious and we will make every effort to accommodate your schedule when planning your appointments. We ask for the same courtesy and will do our best to make sure that we run on time and make each appointment valuable to you and your needs.

SHORT-NOTICE CANCELLATIONS

As a courtesy, please give us a minimum of 24-hours notice if you need to cancel or change an existing appointment. We dedicate 100% of our therapist's time and energy for each hour-long visit with you. **Your recovery is our main goal! Keeping scheduled appointments is how we can make the progress you would like.** Giving us 24-hour notice allows us to accommodate another valuable patient who equally would benefit from our services. We understand that emergencies and personal illnesses may require you to cancel on short-notice and you may do so once without penalty. Any subsequent cancellations will be charged to your account for $35, and repeated short-notice cancellations may be grounds for early discharge. Please note, the cancellation fee is not billable to your insurance provider and is your personal responsibility.

If a short-notice change is required on our part due to staff illness or emergency, you will not be charged a fee. Additionally if an alternative appointment time can be found for a short-notice cancellation, you will not be charged a fee.

MISSED APPOINTMENTS

Any missed appointment without notice, regardless of the reason, will be charged at $80 to your account and is not covered by insurance.

If we are billing a workers' compensation carrier or motor vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee for missed appointments. Please be advised that we may elect to discontinue your treatment after repeated late or missed appointments for those who do not adhere to our policy.

FINANCIAL POLICY

Welcome to Focus Physical Therapy, Inc.! In an effort to make ensure your rehabilitation and treatments with Focus are as stress free as possible we have established a clear financial policy. Below outlines information specific to all aspects of the financial responsibility associated with your recovery. Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.

Focus partners with most regional insurance plans. If you are not insured by a plan that we conduct business with payment in full will be expected at each visit. All patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility. In most cases, Focus will bill your provider, however any account balance incurred with Focus is legally your responsibility. The adult, parent or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Focus and agree to all terms listed herein.

If Focus will be billing a workers' compensation carrier or motor vehicle insurance provider it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information in the event that your workers' compensation or motor vehicle accident claim is denied.

Should your account become overdue our policy is to turn the account over to a collection agency. Any legal fees paid to secure overdue balances will be added to your account and treatment with our facility may be terminated.

Terms of Agreement

I, the undersigned, hereby agree with the following:

- All co-payments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of Focus to collect co-payments and deductibles from patients may be considered fraudulent. I agree to pay my co-payment and/or deductible at each visit.
- I am aware that some, and perhaps all, of the services/equipment I have received may be non-covered, denied by my carrier or not considered reasonable or necessary by Medicare or other providers. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Focus of any change in my information, including but not limited to, address, phone number or insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I certify that I (or my dependent) have insurance coverage as provided to Focus and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a charge of $35 for missed appointments not cancelled within 24-hours of my scheduled appointment time. These charges are my responsibility and not covered by my insurance.

_____ _____

Signature of Patient or Responsible Party **Date**

MEDICAL HISTORY FORM

PLEASE COMPLETE THE FOLLOWING. These two pages tell us about your general health and surgical history.

NAME_____ Today's Date _____

Date of Birth _____ Age_____ Height _____ Weight_____ Gender: M F

Do you have a pacemaker? Yes No **Are you pregnant? Yes No**

Have you fallen in the past year, with or without injury? Yes No If yes, how many times? _____

Occupation _____ Working: Full Time___ Part Time___ Not Employed___ Retired___

Physical Activities at Work: _____

General Health: Excellent___ Good___ Average___ Fair___ Poor___

Date of Last Physical Exam _____

Exercise Level: None___ 1-2x/wk___ 3-4x/wk___ 5+s/wk___

Type of Exercise:_____

Do you experience any symptoms during heavy exercise? Yes No

If yes, please explain _____

Stress Level: Low___ Medium___ High___

Hobbies: _____

Are you currently seeing any of the following? (check all that apply)

- ☐ Medical Doctor
- ☐ Dentist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist
- ☐ Chiropractor
- ☐ Other

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical condition, physical exam, etc.).____

In the past 6 months, have you had (check all that apply)

- ☐ **Difficulty w/bowel/bladder control**
- ☐ **Numbness in the genital/anal area**
- ☐ **Vision/hearing problems**
- ☐ **Unexplained weight change**
- ☐ **Leg swelling**
- ☐ **Fever/chills**
- ☐ **Night pain/sweats**
- ☐ **Dizziness or fainting**
- ☐ **Chest pain**
- ☐ **Other**
- ☐ **Numbness**
- ☐ **Weakness**
- ☐ **Bodily discomfort**
- ☐ **Shortness of breath**

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NAME_____DOB: _____ Today's Date _____

Have you ever been diagnosed as having any of the following? (check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ HIV/Acquired immune deficiency syndrome
- ☐ If yes, what kind?_____
- ☐ Chemical dependency/alcoholism
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Rheumatoid arthritis
- ☐ Arthritic conditions
- ☐ Epilepsy/seizures
- ☐ Other_____
- ☐ Depression
- ☐ Stroke
- ☐ Anemia
- ☐ Kidney disease
- ☐ Allergies
- ☐ Multiple sclerosis

Do you have any of the following risk factors for heart disease? (check all that apply)

- ☐ High blood pressure
- ☐ Smoking
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Family history of heart disease

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition. (attach a separate list if needed)

DATE SURGERY / HOSPITALIZATION REASON

_____ _____

_____ _____

_____ _____

_____ _____

List **ALL** medications including prescriptions, herbal remedies and over the counter, in any form (pills, injections, skin patches) you are currently taking (a separate list can be provided)

_____

_____

Amount of alcohol consumption (# of drinks) per week _____

Number of cigarettes / cigars per week _____

Does any injury or condition significantly impact your function in these areas? (check all that apply)

- ☐ Work
- ☐ Personal care
- ☐ Experiencing withdrawal/depression
- ☐ Mobility at home
- ☐ Safety including risk of falls
- ☐ Other _____
- ☐ Food/meals
- ☐ Transportation

Signature _____

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CURRENT CONDITION/PROBLEM

NAME_____DOB: _____ Today's Date _____

What's going on? (what can we help you with?)

_____

_____

How long has this been going on? (When did these symptoms start? If after surgery, provide surgery date)

_____

How did this injury (or condition) occur?

_____

What's happening now with your symptoms/condition? □ Getting Better □ About the Same □ Getting Worse

Please list any previous treatment for this problem/condition

_____

Have you ever had this problem before? □ YES □ NO

If so, how was the problem treated? _____

What imaging studies have you had for this problem? (x-rays, MRI, etc)? _____

Circle the number that represents **your average level of pain** over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Aggravating Factors: List and rate at least 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

Problem #1 _____

Able to Perform Without Difficulty 0 1 2 3 4 5 6 7 8 9 10 Unable to Perform

Problem #2 _____

Able to Perform Without Difficulty 0 1 2 3 4 5 6 7 8 9 10 Unable to Perform

Problem #3___ _____

Able to Perform Without Difficulty 0 1 2 3 4 5 6 7 8 9 10 Unable to Perform

What makes you feel better or helps your condition?

_____

What do you hope to get out of physical therapy?

_____

Patient Signature _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(To be retained by Medical Provider)

I understand that Focus Physical Therapy Inc (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 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 [optional: and available on website at . . . .]
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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