Advanced Orthopedic
Physical Therapy, P.C.

Thank you for choosing Advanced Orthopedic and welcome!
Please provide your insurance and identification card for our records.

Name: _____ DOB: _____ Female: ☐ Male: ☐

Current Diagnosis: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Social Security #_____ Email:_____

Emergency Contact: _____ Relationship:_____ Phone #: _____

Primary Care Physician: _____ Phone/Address: _____

Referring Physician: _____ Phone/Address: _____

Employment Data
Employer: _____ Phone #: _____

Occupation: _____

Accident Information (Circle One)
None Auto Work Other Date of Injury: _____
Do you have an attorney involved? Yes / No
If yes, his/her Name: _____ Phone Number: _____

Notice to Medicare Patients:

Medicare requires that you visit your referring physician at or before 90 days from the start of Physical Therapy. **If you fail to revisit your physician at or before 90 days and treatment continues past that they will not pay for Physical Therapy services in our office.** If you are continuing treatment with us past the 90 day mark, Medicare then requires that you recheck with your physician every 90 days thereafter.

Please let our staff know when your next appointment with your physician is.

**I understand that I must revisit my physician at least every 90 days for the first set of visits, then every 90 days thereafter or Medicare will deny payment for Physical Therapy Services. I will be personally liable for all charges incurred.

_____ _____
Patient signature Date

******Please inform us of the date of each Doctor visit. ******

Today's Date_____ Must Return to Dr. By_____

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Employment: Unemployed ☐ Light Duty ☐ Part Time ☐ Full Time ☐ Retired ☐ Student ☐
Dominant Hand: Right ☐ Left ☐ **Are you pregnant?** Yes ☐ No ☐
Prescription Medications: _____

_____

Surgical History: _____

Medical History (circle all that you have ever had)

Arthritis
Broken Bones/Fractures
Cancer
Diabetes
Heart Problems
High Blood Pressure
Lung Problems
Osteoporosis
Seizures
Stroke
Head Injury
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

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

Chest Pain
Coordination Problems
Difficulty Sleeping
Headaches
Loss of balance
Visual Problems
Pain at night
Weakness

History of current problem:

When did the problem(s) begin?_____

_____

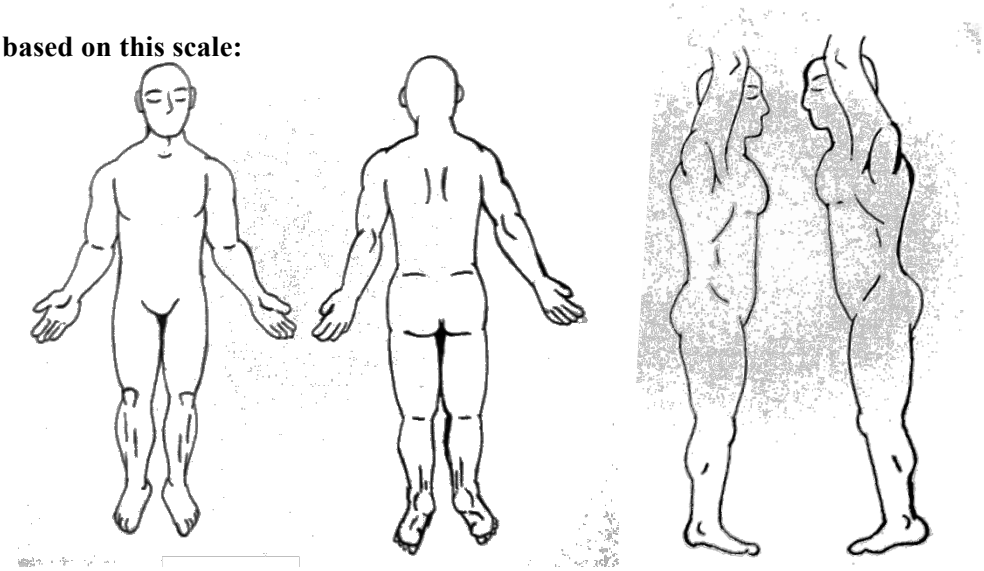
_____

What happened? _____
Have you had this problem(s) before? Yes ☐ No ☐
What makes this problem(s) better? _____
What makes this problem(s) worse? _____

Please sketch the affected areas as follows:

Please rate your pain based on this scale:
0-No pain
1-Very weak
2-Weak
3-Moderate
4-Somewhat strong
5-Strong
6-
7-Very strong
8-
9-Very, very strong
10-Emergency

NOW:_____
Last 30 days:_____



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

Consent to Physical Therapy Intervention: I hereby authorize the healthcare providers of Advanced Orthopedic Physical Therapy to administer physical therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that physical therapy interventions may include, 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.

Print Name:	
Patient Signature:	**Date**
Reviewed by Therapist:	

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FINANCIAL RESPONSIBILITY

I authorize Advanced Orthopedic Physical Therapy, PC to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Advanced Orthopedic Physical Therapy, PC will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts. I agree that, if my account is put into the hands of an attorney for collections, I will be solely responsible for any and all attorney's fees and costs, associated with collecting the overdue amount, whether before a lawsuit is filed, at trial, or on appeal.

By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

X_____ _____
Patient Name Date

X_____ _____
Signature Relationship

X_____ _____
Witness Date

CANCELLATION POLICY

Advanced Orthopedic Physical Therapy, PC takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited.

Any appointment not cancelled within 24 hours of the appointment time, will incur a fee of $30.

If more than 2 cancellations/no shows occur within a patient's recommended plan of care timeframe, Advanced Orthopedic Physical Therapy, PC will hold the right to recommend discontinuing therapy services. The patient will then be removed from their therapist's schedule to allow for other individuals to use this time slot.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Date

Advanced Orthopedic
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Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(II), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1196 (the "Privacy Regulations").

Please read the following information carefully:

a) I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Advanced Orthopedic Physical Therapy, P.C (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

b) I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

c) I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 700 Deborah Rd. Newberg, OR 97115, Attention: Practice Compliance Director.

d) I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by the restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____
_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____ _____
Patient's Name Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted_____Denied _____Not Applicable

_____ _____
Signature of Authorized Practice Representative Date

Advanced Orthopedic
Physical Therapy, P.C.

700 Deborah Rd Ste 190B
Newberg, OR 97132
Phone 503-537-7070 FAX 503-217-7176

Patient

Name (Last, First)	Age	Birth Date	Sex
Mailing Address	City	State	Zip Code	Marital Status
Primary Diagnosis	Primary Numeric Diagnosis	Secondary Numeric Diagnosis

Responsible Party

Name (Last, First)	Age	Birth Date	Sex	Relationship to Patient
Address (put same if same as above)	City	State	Zip Code	Marital Status
Employer	Home Phone	Cell Phone

Referring Provider

Name (Last, First)	Phone	Fax

Primary Insurance Information

Primary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %	Co-Pay	Deductible

Secondary Insurance Information

Secondary Insurance Company	Policy Holder Name	Date of Birth	Policy Number
Insurance Address	City	State	Zip Code	Group Number
Phone Number	Co-Insurance %	Co-Pay	Deductible

Signature of insured or authorized person	Date

Patient Name:	Date:
Physician:	Date of Onset/Injury/Surgery:
Diagnosis:	

SUBJECTIVE:

Chief complaint: _____

_____

Mechanism of injury: _____

Prior/Current level of function: _____

_____

Relevant medical history: _____

Occupation/Activities: _____

Special studies performed: _____

Patient Goals: _____

OBJECTIVE:

Precautions/Barriers to optimal outcome: _____

Posture: _____

Functional mobility: _____

Balance/Coordination: _____

ROM: _____

_____

_____

Strength: _____

_____

_____

Special test/Screens: _____

_____

Neural Tension Test: _____

Segmental mobility/ Joint play: _____

_____

Sensation/Reflexes/ Proprioception: _____

_____

Palpation: _____

Other/Comments: _____

_____

_____

_____

Therapist