

# Patient Registration Form

West Portland  
Physical Therapy  
Clinic LLC



Patient Information		Account # :	
Name:		Date of Birth:	
Address:		Primary Phone:	
Please indicate the best number for your appointment reminder calls: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Text		Alternate Phone:	
Email:	May we contact you via email?		Yes No

## Employer Information

Employer:	Employer Phone:
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## Guarantor Information

Guarantor Name:	Guarantor Phone:
Guarantor Address: (If different from patient):	

## Emergency Contact Information

Emergency Contact:	Emergency Contact Phone:
Relationship:	

## Injury Information

Date of Injury:	Onset Date:	Work Related?	Auto Related	Account Type:
			- State -	-
Description of Injury:				
Is this injury related to a Motor Vehicle Accident?	Yes No	Is this injury related to a Workers Comp claim?	Yes No	

## Physician Information

Referring Physician:	Phone:
Primary Physician:	Phone:
Other Physician:	Phone:

## Primary Policy Information

Name/Address of Insurance	Policy / ID #	Group #	Name of Insured	Insured DOB
Effective Dates				-

## Secondary Policy Information

Name/Address of Insurance	Policy / ID #	Group #	Name of Insured	Insured DOB
Effective Dates				-

I certify that all of the information provided herein is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Initials: \_\_\_\_\_



<b>Name:</b> _____	<b>Date of Birth:</b> _____
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**NOTIFICATION OF PATIENT RESPONSIBILITY**

West Portland Physical Therapy Clinic, LLC ("WPPTC") verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization, or network plan. We request that you check with your health plan for a complete understanding of what will be billed to you.

If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment for services.

Based upon the information that your insurance company quoted to us, your benefits are as follows:

<b>Deductible:</b>	\$	<b>Co-Insurance:</b>	%	<b>Co-Payment:</b>	\$
<b>Benefit Description:</b> _____					

**FINANCIAL RESPONSIBILITY and ASSIGNMENT OF BENEFITS**

I understand that insurance billing is provided as a courtesy and that I am financially responsible to West Portland Physical Therapy Clinic, LLC for all charges arising from my treatment. It is my responsibility to notify WPPTC of any changes in my health care coverage. While WPPTC verifies benefits with my health plan, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies received by me.

I authorize direct payment from my health insurance plan to WPPTC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

**CANCELLATION POLICY**

We are entering into a cooperative partnership with you and your physician to help you attain your maximal rehabilitation goals. We understand that circumstances may arise requiring you to cancel your scheduled appointment.

However, cancellations have a serious impact on the clinic.

If you need to cancel an appointment on Monday, you must notify us by 4:00 pm on Friday to avoid the cancellation fee.

**A \$35.00 fee will be charged to your account if you cancel with less than 24 hours' notice.**

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for WPPTC.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

**CONSENT FOR TREATMENT and RELEASE OF INFORMATION**

I am aware of my diagnosis and wish to receive treatment from WPPTC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to WPPTC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize WPPTC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

**I certify that I have read this agreement and my signature indicates my understanding and consent.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

It is very important for us to stay in touch with your physician. Please provide us with the date of your next appointment.

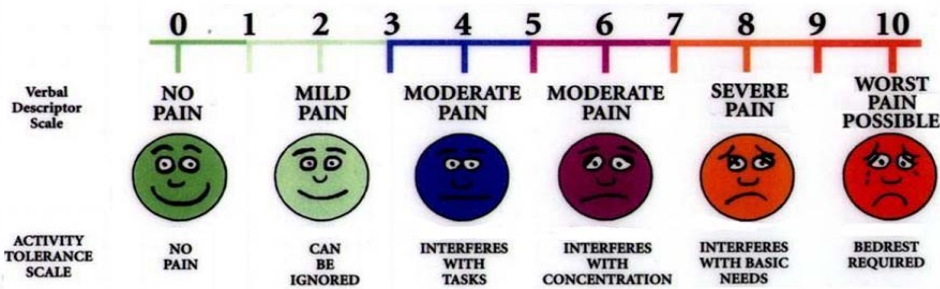
**Next Physician Appointment:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

If you do not have an appointment set, please let us know when you have made your next appointment.

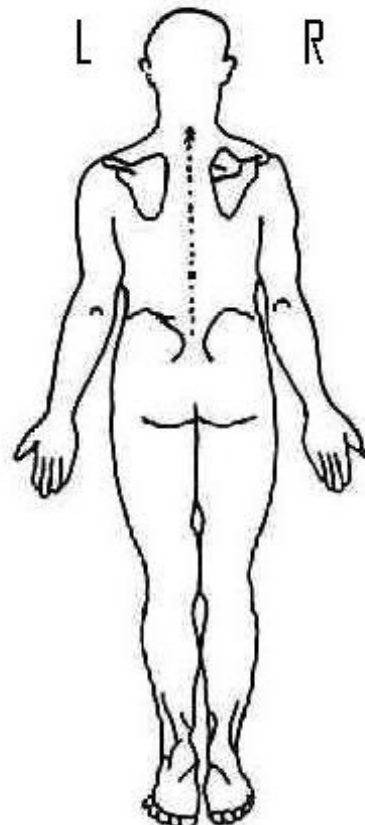
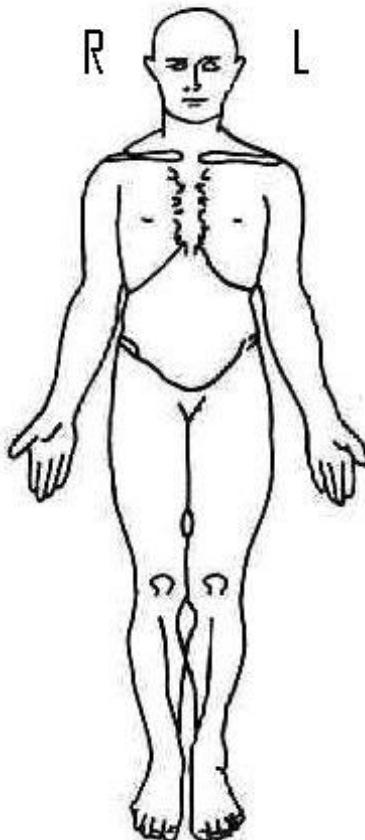
## UNIVERSAL PAIN ASSESSMENT TOOL

Please Circle the Description of your pain in the past week. Circle both your best level of pain and your worst level of pain.



WHERE IS YOUR PAIN?

Please mark the area of your pain on the drawings below.



# Medical History

West Portland  
Physical Therapy  
Clinic LLC



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Have you had surgery for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_ Date: \_\_\_\_\_

## Please list current medications:

Anti-inflammatories: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_

Pain Medication: \_\_\_\_\_

Other: \_\_\_\_\_

## Have you seen other practitioners or had any of the following treatments for your current complaint?

Orthopedist \_\_\_\_\_  
Neurologist \_\_\_\_\_  
Physical Therapist \_\_\_\_\_  
Chiropractor \_\_\_\_\_  
Naturopath \_\_\_\_\_

Massage Therapy \_\_\_\_\_  
Acupuncture \_\_\_\_\_  
X-Rays \_\_\_\_\_  
MRI \_\_\_\_\_  
Other \_\_\_\_\_

## Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	_____	_____	Diabetes	_____	_____
Shortness of Breath / Chest Pain	_____	_____	Gout	_____	_____
Heart Disease or Angina	_____	_____	Anemia	_____	_____
Heart Attack or Surgery	_____	_____	Hernia	_____	_____
High Blood Pressure	_____	_____	Neck Injury	_____	_____
Do You Have a Pacemaker?	_____	_____	Back Injury	_____	_____
Blood Clot or Emboli	_____	_____	Knee Injury	_____	_____
Infectious Diseases	_____	_____	Hand or Wrist Injury	_____	_____
Numbness or Tingling	_____	_____	Elbow Injury	_____	_____
Dizziness or Fainting	_____	_____	Shoulder Injury	_____	_____
Metal in Body or Surgical Implants	_____	_____	Ankle or Foot Injury	_____	_____
Joint Replacement	_____	_____	Do you smoke?	_____	_____
Sleeping Problems or Difficulties	_____	_____	Are you currently pregnant?	_____	_____
Bowel or Bladder Problems	_____	_____	Are you allergic to latex?	_____	_____
Emotional / Psychological Problem	_____	_____	Unexplained Weight Loss / Gain	_____	_____
Osteoporosis	_____	_____	Is your pain relieved by rest or bed rest?	_____	_____
Arthritis (Rheumatoid)	_____	_____	Do you have a history of cancer?	_____	_____
Stroke / TIA	_____	_____	(especially breast, prostate, or lung cancer)		

## Please list any past surgeries that you have had and the date:

Are you aware of your current diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_

## What are your expectations and goals of treatment?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Women's Health / Pelvic Floor Questionnaire

West Portland  
Physical Therapy  
Clinic LLC



Name:

Date of Birth:

Please answer the following questions so that we can best help you manage your concerns.

Do you now or have you had a history of the following?

	NOW	PAST		NOW	PAST
Bladder Infections	_____	_____	Constipation	_____	_____
Painful Intercourse	_____	_____	Abdominal Pain	_____	_____
Menopause	_____	_____	Endometriosis	_____	_____
Pelvic Pain	_____	_____	STD	_____	_____

Explain the above responses: \_\_\_\_\_

Previous treatment and effectiveness:

\_\_\_\_\_  
\_\_\_\_\_

List surgeries and dates:

\_\_\_\_\_  
\_\_\_\_\_

Any current exercise program:

\_\_\_\_\_  
\_\_\_\_\_

## Birth History

Number of pregnancies: \_\_\_\_\_

Number of deliveries: \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Date of birth \_\_\_\_\_

Size of Child \_\_\_\_\_

Problems \_\_\_\_\_

Please indicate areas where you have pain:

\_\_\_\_\_

Please describe any activities or things that you cannot do because of your problem:

\_\_\_\_\_

Do you have any other concerns or problems not asked?

\_\_\_\_\_

\_\_\_\_\_

# Consent Form Internal Pelvic Floor Evaluation

West Portland  
Physical Therapy  
Clinic LLC



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In order to fully understand the scope of your individual diagnosis there is some very important information your therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers she will ask you privately.

- |  | Yes            | No             |
|--|----------------|----------------|
| 1. Are you currently sexually active?<br>If "no", have you been sexually active in the past? | _____<br>_____ | _____<br>_____ |
| 2. Do you have any communicable diseases?<br><br>If yes, please describe _____               | _____          | _____          |
| 3. Has there been any sexual abuse in your past  | _____          | _____          |
| 4. Have you had difficulty with past vaginal exams?  | _____          | _____          |

I give / deny my consent for my therapist to do a vaginal/rectal examination for the purpose of evaluating my condition and determining therapeutic treatment.  
(please circle)

1. I understand that I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of having a second person present in the room during this procedure and I refuse / choose this option.  
(please circle)
4. I have read this consent form and understand its terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_