

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: |

| | |
|---|------------------|
| 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: _____



| | |
|--------------------|-----------------------------|
| Name: _____ | Date of Birth: _____ |
|--------------------|-----------------------------|

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:

| | | | | | |
|-----------------------------------|----|----------------------|---|--------------------|----|
| Deductible: | \$ | Co-Insurance: | % | Co-Payment: | \$ |
| Benefit Description: _____ | | | | | |

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.

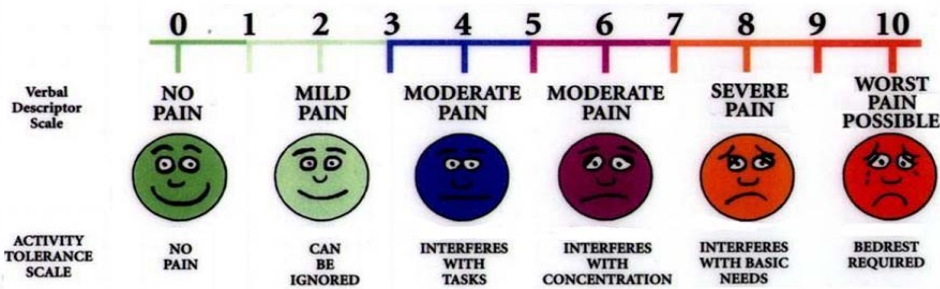
Next Physician Appointment: _____

Today's Date: _____

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

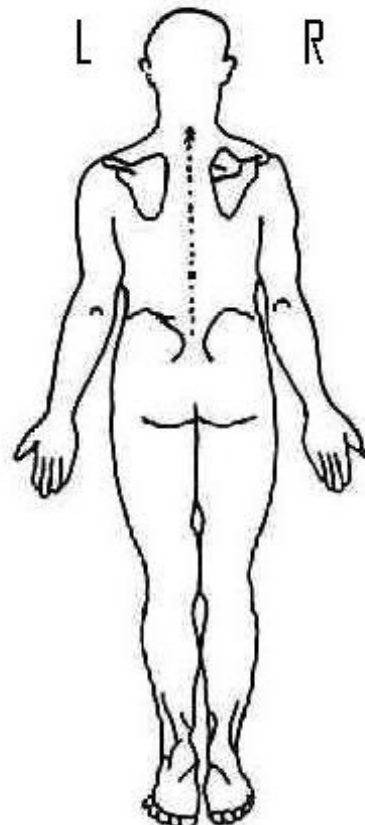
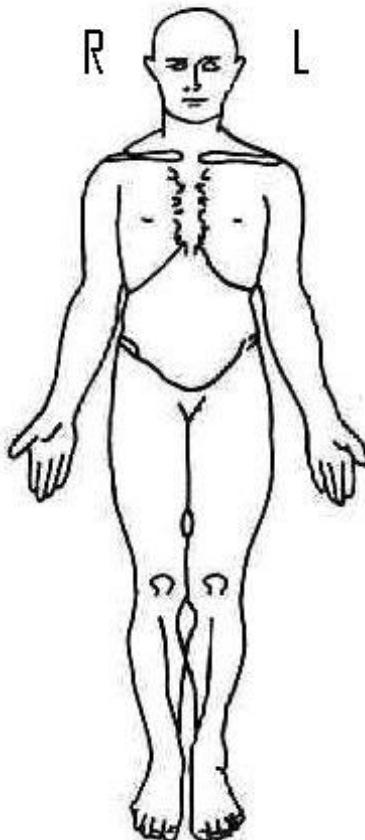
UNIVERSAL PAIN ASSESSMENT TOOL

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: _____

Men's Health / Pelvic Floor Questionnaire

West Portland
Physical Therapy
Clinic LLC



| | |
|--|---|
| Name: <input style="width: 95%;" type="text"/> | Date of Birth: <input style="width: 95%;" type="text"/> |
|--|---|

Please circle the number below which applies to your symptoms over the past month:

| | Never | Moderate | Severe | | |
|---|-------|----------|--------|---|---|
| Pain in the rectum..... | 0 | 1 | 2 | 3 | 4 |
| Pain in the groin or lower abdomen..... | 0 | 1 | 2 | 3 | 4 |
| Pain in the buttocks..... | 0 | 1 | 2 | 3 | 4 |
| Pain in the testicles..... | 0 | 1 | 2 | 3 | 4 |
| Pain in the penis..... | 0 | 1 | 2 | 3 | 4 |
| Prostate pain..... | 0 | 1 | 2 | 3 | 4 |
| Pain in the sacrum or low back..... | 0 | 1 | 2 | 3 | 4 |
| Pain during or following intercourse..... | 0 | 1 | 2 | 3 | 4 |
| Pain with sitting..... | 0 | 1 | 2 | 3 | 4 |
| Pain with urination..... | 0 | 1 | 2 | 3 | 4 |

List any other activities that increase your pain in the pelvic region:

Do you have difficulty getting or maintaining an erection? NO YES

Do you experience urinary incontinence? NO YES

Are you wearing pads / diapers for protection? NO YES
(please circle)

If so, how many do you wear a day? _____

Do you use any other form of protection, and if so what? _____

Do you experience urinary urgency? NO YES

On average how many times do you urinate during the day? _____

On average how many times do you urinate at night? _____

Do you have difficulty stopping the flow of urine? NO YES

Do you have difficulty starting the flow of urine? NO YES

Consent Form Internal Pelvic Floor Evaluation

West Portland
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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? | _____ | _____ |
| If "no", have you been sexually active in the past? | _____ | _____ |
| 2. Do you have any communicable diseases? | _____ | _____ |
| If yes, please describe _____ | | |
| 3. Has there been any sexual abuse in your past | _____ | _____ |

I give / deny my consent for my therapist to do a 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 my physical therapist 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: _____