

# Hood River Physical Therapy, Inc.

## MVA / LIABILITY PATIENT INFORMATION

Name _____	SS# _____ - _____ - _____	Sex M ___ F ___
Address _____	City _____	State _____ Zip _____
Home Phone (_____) _____	Message Phone (_____) _____	
Birth Date ____/____/____	Marital Status S ___ M ___	Email Address: _____
Nearest Relative/Emergency Contact _____		Phone (_____) _____
Name of Responsible Party _____		Relationship to patient _____
Employer _____		work phone (_____) _____
Address _____		City _____ State _____ Zip _____
Is your referral to Physical Therapy related to a <u>Motor Vehicle Accident</u> ? If Yes, MVA Date ____/____/____		
If not MVA, please explain type of accident _____		
Have you retained an attorney? Yes ___ No ___ Attorney's Name _____		
Attorney's Address _____		City _____ State _____ Zip _____
Attorney's phone (_____) _____		Would you like all correspondence directed to you attorney? Yes ___ No ___

How did you choose our practice? (check all that apply) Friend/Relative: Name \_\_\_\_\_ (so we may thank them)  
Hospital \_\_\_ Ins Co. \_\_\_ Yellow Pages \_\_\_ Physician \_\_\_ Former Patient \_\_\_ Employer \_\_\_ Website \_\_\_ Other \_\_\_

### INSURANCE INFORMATION

(Please present your insurance card(s) for copying)	
Patient's MVA/Liability Insurance _____	
Insurance Address _____	City _____ State _____ Zip _____
Subscriber _____	Policy ID # _____ CL # _____
Phone (_____) _____	Adjuster/Contact Person _____
Patient's Medical Insurance _____	
Subscriber _____	Birth Date ____/____/____ Relationship _____
Policy ID# _____	Group # _____

### FINANCIAL RESPONSIBILITY

As a service, HRPT will submit the charges for your treatment to your primary and secondary insurance company, however, it is your responsibility to pay any amounts not paid by your insurance.

1.) HRPT will add a 15% per annum interest on all 'patient balance' amounts if that balance is not paid in full within 30 days after it is due.

2.) If we are required to send your account to a third party for accounts receivable assistance, a \$25.00 fee may be applied to your account. If we are required to send your account to collections, a \$50.00 fee may be applied to your account.

I have read and understand the above information regarding HRPT's policies.

I authorize payment of medical benefits to Hood River Physical Therapy, Inc. for professional services rendered. I authorize the release of any medical information necessary to process this claim. I authorize release of medical records and x-rays from any physician or medical facility necessary and related to my medical treatment to Hood River Physical Therapy, Inc.

● Patient Signature \_\_\_\_\_  
If patient is under 18 years of age, a parent or guardian must sign.

● Date \_\_\_\_\_

**HOOD RIVER PHYSICAL THERAPY, INC.**  
**Patient Medical History**

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank You

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ PHONE # WORK/DAY: \_\_\_\_\_

LEISURE ACTIVITIES: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Please check if you are currently seeing any of the following health care professionals:

Medical Doctor \_\_\_\_\_ Psychiatrist/Psychologist \_\_\_\_\_ Osteopath \_\_\_\_\_  
 Occupational Therapist \_\_\_\_\_ Dentist \_\_\_\_\_ Chiropractor \_\_\_\_\_

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

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

Have you **ever** been diagnosed as having any of the following conditions? (If YES, please check)

Cancer...If YES, describe what kind: \_\_\_\_\_

Heart problems _____	Diabetes _____	Depression _____
High blood pressure _____	Asthma _____	Hepatitis _____
Emphysema/Bronchitis _____	Tuberculosis _____	Stroke _____
Chemical dependency _____	Thyroid problems _____	Kidney disease _____
Multiple sclerosis _____	Anemia _____	Rheumatoid arthritis _____
Other arthritic conditions _____	Epilepsy _____	Other _____

Are you currently pregnant? Yes / No EDD (if yes): \_\_\_\_\_

Have you recently experienced unexplained weight loss or gain? Yes / No

Have you experienced loss of bowel or bladder control? Yes / No

Are you experiencing any of the following?

Dizziness \_\_\_\_\_ Difficulty speaking \_\_\_\_\_ Difficulty swallowing \_\_\_\_\_  
 Drop Attacks \_\_\_\_\_ Double Vision \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization:

<u>DATE</u>	<u>SURGERY/HOSPITALIZATION</u>	<u>REASON</u>
-------------	--------------------------------	---------------

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

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

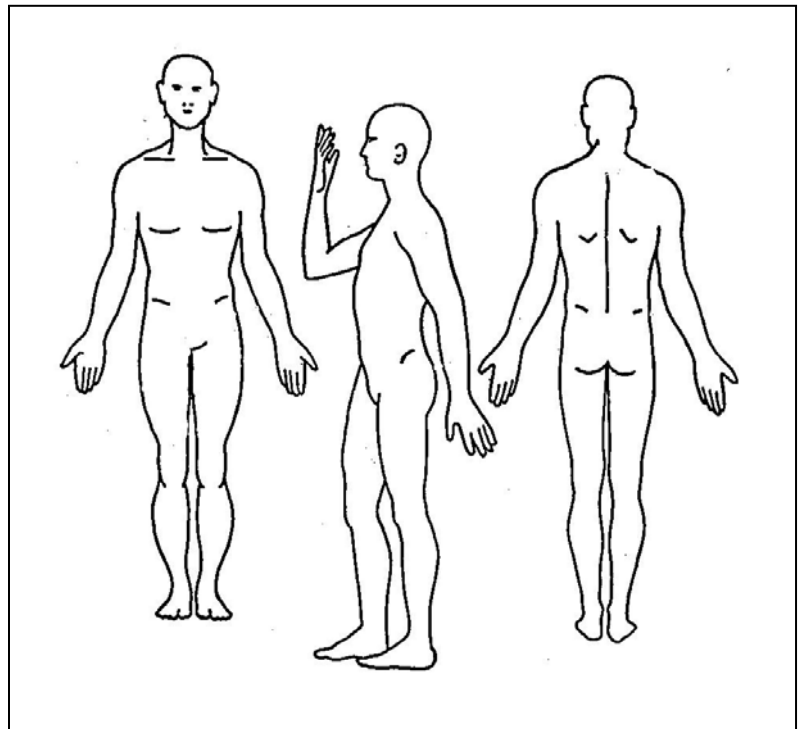
<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your **immediate family** (parents, brothers or sisters) ever been treated for the following?

Diabetes _____	Cancer _____	Tuberculosis _____
Arthritis _____	Heart disease _____	Anemia _____
High blood pressure _____	Headaches _____	Stroke _____
Epilepsy _____	Kidney disease _____	
Alcoholism (chemical dependency) _____		

Which of the following **over-the counter** medications have you taken **in the last week**?

Aspirin  
 Tylenol  
 Advil/Motrin/Ibuprofen  
 Laxatives  
 Decongestants  
 Antihistamines  
 Antacid  
 Vitamins/mineral supplements  
 Other \_\_\_\_\_



Please list any **prescription** medication you are currently taking (**including** pills, injections, and/or skin patches):

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

Please list the activities that aggravate your pain? \_\_\_\_\_

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

Please list the your current strategies to help alleviate your pain? \_\_\_\_\_

\_\_\_\_\_

Please indicate areas of pain and discomfort (on the figures above) using the following symbols:

/// = pain                      +++ = abnormal feeling  
 \*\*\* = numbness                ooo= other \_\_\_\_\_

Please rate your pain on a scale of 0 - 10: \_\_\_\_\_  
 (10 being the worst pain, 0 being no pain)



# HOOD RIVER PHYSICAL THERAPY

2690 May Street, Hood River, OR 97031 Phone 541-386-2441 Fax 541-386-5869

## HOOD RIVER PHYSICAL THERAPY, INC NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT  
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET  
ACCESS TO THIS INFORMATION**

**PLEASE REVIEW THIS CAREFULLY.**

*If you have any questions about this notice, please contact the Office Manager our designated privacy official of Hood River Physical Therapy at 541-386-2441  
2690 May Street  
Hood River, Oregon 97031*

This notice describes the procedures and practices that this clinic and its professional, support and administrative staff follow to protect the privacy of your health information.

### YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, the doctor who referred you for physical therapy may be treating you for a medical or orthopedic condition and we may need to know about that and any other health problems that could complicate your treatment. We may use your medical history to decide what treatment is best for you. We will consult with your doctor and send reports about your treatment to the doctor. We do this to provide the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as telephoning your doctor and getting needed information. Family members and other health care providers may be part of your physical therapy outside this office and that may require us to provide information about you.

- **For payment.** We may need to disclose health information about you in order to bill your health plan or insurance company or other third party for your treatment in this clinic.

We may also need to tell your health plan or insurance company about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to manage the clinic and ensure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain treatments are effective for certain problems.

We may also disclose your health information to your health plan and other health care providers that care for you in order to help these plans and providers evaluate or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you to remind you of your appointment.
- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may interest you.
- **Health-Related Products and Services.** We may tell you about health-related products or services that may interest you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive these communications, we will not use or disclose your information for these purposes.

#### OTHER CIRCUMSTANCES

We may use or disclose health information about you for the following purposes, in accordance with the requirements and limitations of state and other law:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report suspected abuse or neglect, non-accidental physical injuries or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

#### OTHER USES AND DISCLOSURES PURSUANT TO YOUR SIGNED AUTHORIZATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you sign an *Authorization* for us to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

#### YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Office Manager in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Correct.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request a correction as long as the information is kept by this office.

To request a correction, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Office Manager. We will provide you with one of these forms at your request.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to correct information that:

- We did not create, unless the person or entity that created the information is no longer available to make the correction
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a record of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The record may also exclude any disclosures we have made based on your written authorization.

To obtain this accounting, you must submit your request **in writing** to the Office Manager. It must state the time period for which you want an accounting. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Office Manager. We will provide you with one of these forms at your request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail or e-mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact the Office Manager at Hood River Physical Therapy, Inc.

#### CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice or a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

#### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Office Manager and Chief Privacy Officer at 541-386-2441. ***You will not be penalized for filing a complaint.***

**HOOD RIVER PHYSICAL THERAPY, INC  
ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

(To be retained in patient's chart)

I, \_\_\_\_\_, have received or been offered a copy of this office's  
{Please Print Name}

Notice of Privacy Practices.

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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For Office Use Only

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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)