

Hood River Physical Therapy, Inc.

MEDICARE 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 (_____) _____	

How did you choose our practice? (check all that apply):

Friend/Relative: Name _____ (so we may thank them)

Physician____ Former Patient ____ Employer____ Hospital____ Ins Co.____ Yellow Pages____ Website____ Other____

INSURANCE INFORMATION

(Please present your insurance card(s) for copying)	
Medicare Id # _____	Are you presently working? Yes____ No____
Are you Clear Choice? Yes____ No____	
Supplemental / Secondary Medical Insurance _____	
Subscriber's Name _____	Birth Date ____/____/____
Relationship to Patient _____	Policy ID# _____ Group # _____

FINANCIAL REPSONSIBILTY

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 _____

● 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:

DATE SURGERY/HOSPITALIZATION REASON

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

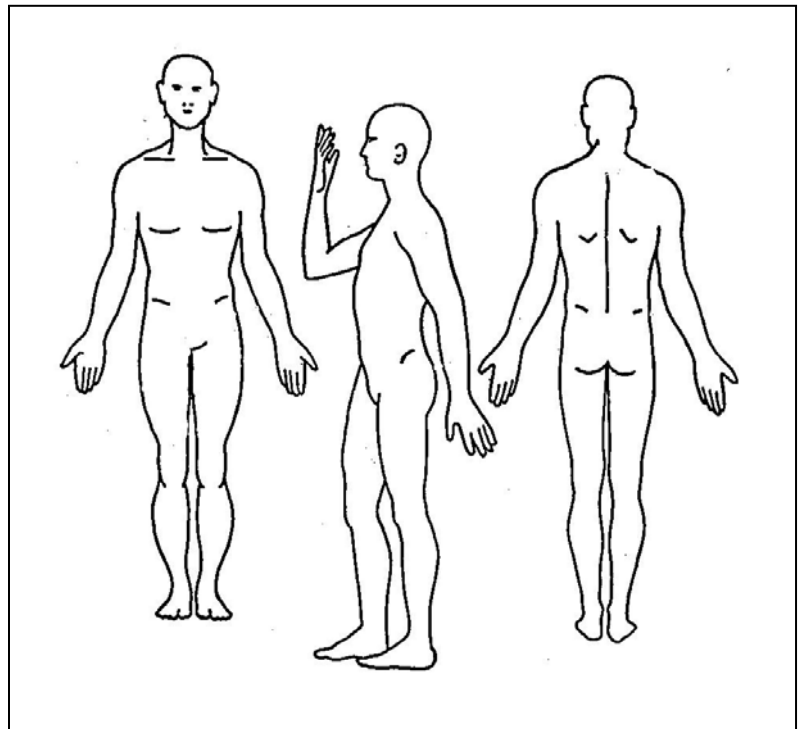
<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

/// = pain +++ = abnormal feeling
 *** = numbness ooo = other _____

Please list the activities that aggravate your pain? _____

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 541-386-2441 fax 541-386-5869 www.hoodriverPT.com

HRPT Policy / Patient Agreement Form

1. PAYMENTS: All applicable fees, co-pays or supply purchases must be paid at the time of your appointment. We accept cash, checks, VISA, Master-Card.

EMAIL MY STATEMENT: _____
(I understand that e-mail sent from Hood River Physical Therapy is not encrypted and may not be secure)

MAIL MY STATEMENT: _____

2. CANCELLATIONS: If you need to cancel your appointment, please be sure to call us at 541-386-2441 at least 24 hours before your scheduled appointment time. *Otherwise, a \$10 fee may apply.*

3. APPOINTMENT TIME: We ask that our patients arrive on time for their appointments. This will facilitate our ability to give you the treatment that you need. In an effort to serve all our patients effectively, patients arriving 10 minutes past their appt time may be rescheduled.

4. CHANGE OF INFORMATION: Please provide us with any changes regarding your address, telephone number(s) or insurance information as soon as possible, so we can update our records.

5. CELL PHONES: Please keep your cell phone turned off during your appointments as a courtesy to our patients and staff.

6. FRAGRANCES / PERFUME / COLOGNE: Due to allergies or patient sensitivity we ask that you please help us try and keep this environment fragrance free.

I, the Guarantor and Responsible Party, agree to the above policies and agree to the terms regarding payment and responsibilities.

Signature

Date

Printed Name

