

**Hood River Physical Therapy, Inc.**  
**OHP, OMAP, WDSHS PATIENT INFORMATION**

Name _____ SS# _____ - _____ - _____ Sex M ___ F ___	
Address _____ City _____ State _____ Zip _____	
Home Phone (_____) _____	Message Phone (_____) _____
Birth Date ____/____/____ Marital Status S ___ M ___ <b>Email Address:</b> _____	
Nearest Relative/Emergency Contact _____ Phone (_____) _____	
Name of Responsible Party _____ Relationship To Patient _____	
Employer _____	Work Phone (_____) _____
Address _____ City _____ State _____ Zip _____	

*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**

<small>(Please present your insurance card(s) for copying)</small>	
<b>Patient's Primary Medical Insurance</b> _____ Policy ID # _____	
Insurance Address _____ City _____ State _____ Zip _____	
Phone (_____) _____	
Subscriber's Name _____	Birth Date ____/____/____
<b>Patient's Secondary Medical Insurance</b> _____ Policy ID# _____	
Subscriber's Name _____	Birth Date ____/____/____
Relationship to Patient _____ 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 \_\_\_\_\_

● Date \_\_\_\_\_

If patient is under 18 years of age, a parent or guardian must sign.

**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:

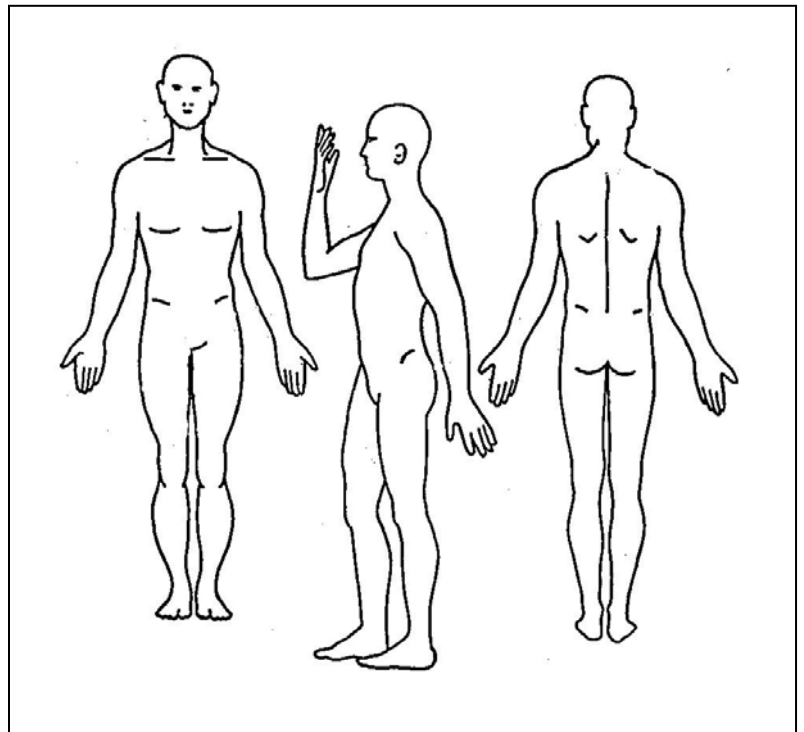
<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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](http://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

