



Corvallis Sport and Spine Physical Therapy, Inc.
 2101 NW Professional Drive, Suite II, Corvallis, OR 97330
 Phone: 541-752-0545 FAX: 541-757-0545

Patient Information			
Patient Name (Last, First Middle)	Gender M F	Date of Birth	Social Security No.
Address	Home Phone No.		Cell Phone No.
City, State Zip	Primary Care Physician		
Email Address	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Who should receive statement?	Occupation		
Employer	Employer Address		
In Case of Emergency, Notify		Contact Phone No.	
Referred By		Date of next visit	
Would you like to receive the CSS Quarterly Newsletter via email YES <input type="checkbox"/> NO <input type="checkbox"/>			
Was your injury a result of an accident? YES <input type="checkbox"/> NO <input type="checkbox"/> Auto Accident <input type="checkbox"/> On the Job Injury <input type="checkbox"/>			
May we contact you at home or work to remind you of your scheduled appointments? YES <input type="checkbox"/> NO <input type="checkbox"/>			

Do you have insurance coverage? YES NO

Insurance Information			
The information below will assist us in determining if some of the expenses are reimbursable by your insurance carrier. We cannot guarantee coverage by your insurance carrier. Please give your insurance card to our receptionist to be copied.			
Primary Insurance Carrier	ID#	Group#	Social Security No.
Name of Insured	Relationship to Patient	Date of Birth	Gender M F
Address	Home Phone No.	Work Phone No.	
City, State Zip	Occupation	Employer	
Secondary Insurance Carrier	ID#	Group#	Social Security No.
Name of Insured	Relationship to Patient	Date of Birth	Gender M F
Address	Home Phone No.	Work Phone No.	
City, State Zip	Occupation	Employer	

Auto and On the Job Injury	Name of Insurance Carrier	Claim #	Date of Injury
	Address		Adjuster Name
	City, State Zip		Adjuster Phone No.

For Office Use Only					
Primary Dx Codes:	1. _____	2. _____	3. _____	4. _____	Therapist



corvallis sport and spine
PHYSICAL THERAPY

Orthopedic Initial Questionnaire

Name: _____

Date: _____

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

- 1. Briefly describe how your symptoms began or how your injury occurred? _____

- 2. When did your symptoms start? _____
- 3. What are your symptoms (i.e., pain, numbness, tingling)? _____

4. Where are your symptoms? Please mark on the diagram at the right.

5. The onset of my symptoms was Gradual Sudden

6. Date of first doctor's appointment for this injury or for these symptoms. _____

7. My symptoms have worsened remained the same improved

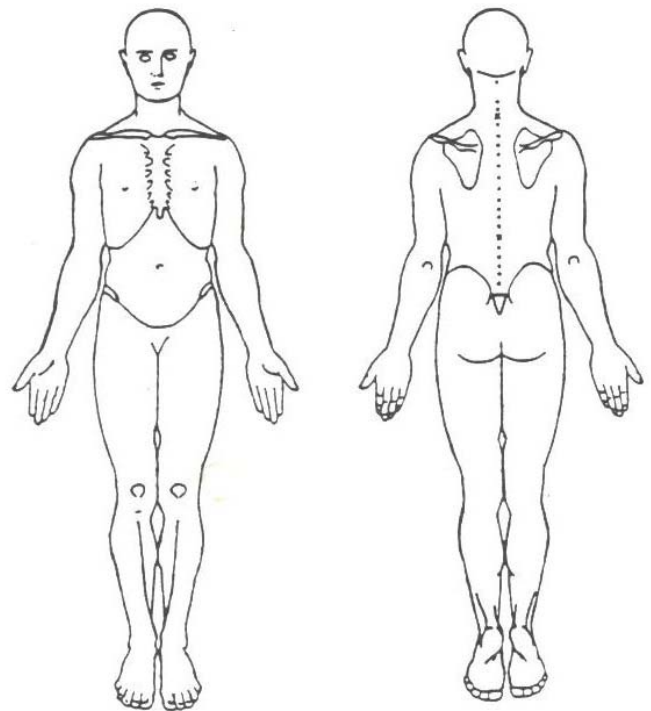
8. My pain over the last few days has been (0-10) _____

9. My symptoms bother me constantly most of the time occasionally

10. Type of pain? Sharp Dull Throb Ache Burning

11. What makes your symptoms worse? _____

12. What makes your symptoms better? _____



13. Since the onset of this injury, have you noticed any of the following:
a. Regular numbness or tingling? Yes No If yes, where? _____

b. Bowel/bladder control difficulties? Yes No

14. Have you had any imaging of your injury? Yes No If yes, when did you have your imaging? _____
 Xray MRI Bone Scan CT Scan Ultrasound

What were the results? _____

15. Have you had this pain or problem before? Yes No

If yes,

a. did you receive any treatment? Yes No If yes, did the treatment help? Yes No

b. what did the treatment consist of? _____

16. What are your goals for physical therapy? _____

17. Is there anything else about you or your condition that you would like us to know? _____

18. Medical History

Please list any surgeries or injuries, for which you have been treated, including fractures, dislocations, sprains.

Date

Surgery Injury _____

Surgery Injury _____

Surgery Injury _____

Please review the following conditions. Do you now have or have you ever been diagnosed with any of the following?

ASTHMA	Y/N	EMPHYSEMA	Y/N	SENSITIVITY TO HEAT/COLD	Y/N
CANCER _____	Y/N	OTHER LUNG PROBLEMS	Y/N	TUBERCULOSIS	Y/N
DIABETES	Y/N	HIV/AIDS	Y/N	OSTEOPOROSIS	Y/N
RHEUMATOID	Y/N	SEVERE/FREQUENT	Y/N	SEIZER DISORDER	Y/N
ARTHRITIS/LUPUS		HEADACHES			
OSTEO ARTHRITIS	Y/N	THYROID PROBLEMS	Y/N	HERNIA	Y/N
HEART PROBLEMS	Y/N	KIDNEY PROBLEMS	Y/N	STROKE	Y/N
HIGH BLOOD PRESSURE	Y/N	LIVER PROBLEMS	Y/N	ANEMIA	Y/N
HEAD INJURY	Y/N	HEPATITIS _____	Y/N	PACEMAKER	Y/N
ALLERGIES _____	Y/N	MULTIPLE SCLEROSIS	Y/N	INCONTINENCE	Y/N

Have you recently noticed any of the following?

WEIGHT GAIN/LOSS	Y/N	FATIGUE	Y/N	DIZZINESS	Y/N
NAUSEA/VOMITING	Y/N	WEAKNESS	Y/N	FEVER/CHILLS/SWEATS	Y/N
NIGHT PAIN	Y/N				

Are you pregnant? Yes No If yes, what is your expected due date? _____

MEDICATIONS

Circle any OVER-THE-COUNTER medications you have taken in the last week.

- Aspirin
- Tylenol
- Advil/Motrin/Ibuprofen/Aleve
- Laxatives
- Decongestants
- Antihistamines
- Antacids
- Vitamins/Mineral Substances

Please list any PRESCRIPTION medication you are currently taking (including pills, injections, and/or skin patches) _____

What do you do for recreation? _____

What is your mode of exercise? _____

Form reviewed with patient? Yes No

Patient Signature: _____

Date: _____

PT Signature: _____

Date: _____



corvallis sport and spine
PHYSICAL THERAPY

Post-Operative Initial Questionnaire

Name: _____

Date: _____

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. What are your symptoms following surgery (i.e., pain, numbness, tingling, loss of strength, loss of mobility)? _____

2. Where did you have surgery? Please mark on the diagram at the right.

3. When did you have surgery? _____

4. What did the doctor remove or repair? _____

5. When did your symptoms originally start? _____

6. The onset of my symptoms was Gradual Sudden

7. Briefly describe how your symptoms began or how your injury occurred? _____

8. Date of first doctor's appointment for this injury or for these symptoms. _____

9. Since surgery, my symptoms have
 worsened remained the same improved

10. What type of problems are you experiencing now? _____

11. My symptoms bother me constantly most of the time occasionally never

12. My pain over the last few days has been (0-10) _____

13. Type of pain? Sharp Dull Throb Ache Burning

14. What makes your symptoms worse? _____

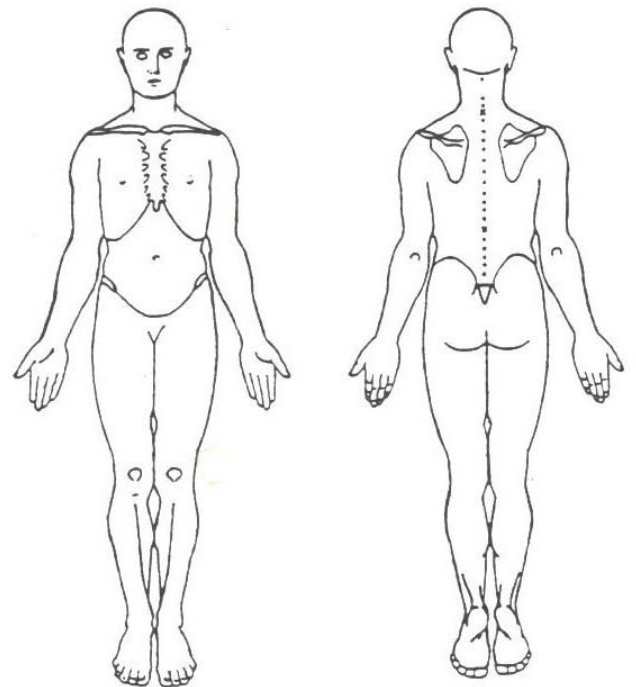
15. What makes your symptoms better? _____

16. Have you had any imaging of your injury? Yes No If yes, when did you have your imaging? _____
 Xray MRI Bone Scan CT Scan Ultrasound

What were the results? _____

17. Do you have any numbness or tingling now? Yes No If yes, where? _____

18. Do you have any bowel/bladder control difficulties now? Yes No



19. What are your goals for physical therapy? _____

20. Is there anything else about you or your condition that you would like us to know? _____

21. Medical History

Please list any surgeries or injuries, for which you have been treated, including fractures, dislocations, sprains.

Date

Surgery Injury _____

Surgery Injury _____

Surgery Injury _____

Please review the following conditions. Do you now have or have you ever been diagnosed with any of the following?

ASTHMA	Y/N	EMPHYSEMA	Y/N	SENSITIVITY TO HEAT/COLD	Y/N
CANCER _____	Y/N	OTHER LUNG PROBLEMS	Y/N	TUBERCULOSIS	Y/N
DIABETES	Y/N	HIV/AIDS	Y/N	OSTEOPOROSIS	Y/N
RHEUMATOID	Y/N	SEVERE/FREQUENT	Y/N	SEIZER DISORDER	Y/N
ARTHRITIS/LUPUS		HEADACHES			
OSTEO ARTHRITIS	Y/N	THYROID PROBLEMS	Y/N	HERNIA	Y/N
HEART PROBLEMS	Y/N	KIDNEY PROBLEMS	Y/N	STROKE	Y/N
HIGH BLOOD PRESSURE	Y/N	LIVER PROBLEMS	Y/N	ANEMIA	Y/N
HEAD INJURY	Y/N	HEPATITIS _____	Y/N	PACEMAKER	Y/N
ALLERGIES _____	Y/N	MULTIPLE SCLEROSIS	Y/N	INCONTINENCE	Y/N

Have you recently noticed any of the following?

WEIGHT GAIN/LOSS	Y/N	FATIGUE	Y/N	DIZZINESS	Y/N
NAUSEA/VOMITING	Y/N	WEAKNESS	Y/N	FEVER/CHILLS/SWEATS	Y/N
NIGHT PAIN	Y/N				

Are you pregnant? Yes No

If yes, what is your expected due date? _____

MEDICATIONS

Circle any OVER-THE-COUNTER medications you have taken in the last week.

Aspirin
Tylenol
Advil/Motrin/Ibuprofen/Aleve
Laxatives
Decongestants
Antihistamines
Antacids
Vitamins/Mineral Substances

Please list any PRESCRIPTION medication you are currently taking (including pills, injections, and/or skin patches) _____

What do you do for recreation? _____

What is your mode of exercise? _____

Form reviewed with patient? Yes No

Patient Signature: _____

Date: _____

PT Signature: _____

Date: _____

Corvallis Sport and Spine Physical Therapy, Inc.
Office Payment Policies, Release of Information and Consent for Treatment

It is the policy of Corvallis Sport and Spine Physical Therapy that payment is due and to be made at the time service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are consistent with other clinics in the area. If you are covered by health insurance with physical therapy benefits, we will gladly bill your insurance for you. You will be asked to provide this information to the office manager upon your first visit and we will verify your coverage as a courtesy. It is your responsibility to familiarize yourself with your particular benefit package as you know your policy better than we do. Occasionally, there are discrepancies in what you and the insurance company understand your policy to entail. We base our billing on the information the insurance company provides us. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not automatically guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred. The physician referral and our verification of insurance benefit do not guarantee payment. Do not assume that you will not owe anything if you have more than one insurance policy.

Please initial next to your payment method and sign below that you have read, understand, and agree with all of the information in this policy.

_____ 1. **PRIVATE HEALTH INSURANCE (PPO).** Some insurance plans require authorization and/or a referral from your primary care physician. Most insurance companies have a deductible (i.e., amount paid by the patient before the insurance coverage begins) and either a co-pay (i.e, a set dollar amount per visit) or coinsurance (i.e., a percent of the allowed charges). Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. **Deductibles and co-pays are due at the time of service.** We will bill you for coinsurance or other balances due after we have been paid by your insurance company or notified of their denial for payment.

_____ 2. **HMO INSURANCE.** Authorization from your insurance must be obtained prior to treatment. **Any co-pay or coinsurance is due at the time of treatment.** Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. If your HMO plan also has a Point of Service (POS) option, please be sure you understand the difference in your coverage.

_____ 3. **MEDICARE.** Corvallis Sport and Spine Physical Therapy, Inc. is a Medicare Preferred Provider. Medicare has an annual deductible of \$100.00 for PT and Speech. Medi-Gap insurance covers the patient's portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. Please verify your insurance benefits and be sure you understand your insurance coverage.

_____ 4. **CASH PAY.** We will be happy to accept cash pay patients and you will receive a **discount** off our fees. **Payment is due at the time service is rendered** and you will receive a receipt. If you have insurance and we are not a preferred provider, you may pay by cash and may be reimbursed by your insurance company. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service.

_____ 5. **WORKER'S COMPENSATION CLAIMS.** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the name and number of your adjuster as well as your claim number, the date of injury and any other pertinent information. Remember, most worker's compensation carriers have up to 90 days to accept your claim. If they deny your claim, you are responsible for the balance. We will be happy to bill your personal health insurance company at that time. If they deny your claim, you will be responsible for the entire balance. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company.

Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change.

_____ **6. THIRD PARTY PAYERS AND AUTO LIENS.** We will bill your insurance, however, third party payments will be sent to you for services we provide. Charges for supplies such as braces, tape, cold-packs, exercise balls and tubing are due at the time of service. A receipt will be provided and you may attempt to be reimbursed by your insurance company. You are responsible for payment of all services provided. Be sure to contact the office when your case is settled to ensure your account has been paid. Please sign a release of information authorization allowing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid.

_____ **RETURNED CHECKS.** Returned checks will be charged a \$45.00 fee.

_____ **BILLING INFORMATION.** Past due accounts (i.e., over 90 days) will be subject to a \$10 re-billing fee. If no payment is received or your account is not made current, we will initiate collection procedures. You will be responsible for all incurred fees related to the collection of your account including attorney, collection service, and court costs.

_____ **CANCELLATION AND NO-SHOW POLICY.** Should you not be able to make a previously scheduled appointment, a 24-hour notice of cancellation must be provided by phone, email or in person. **If notification of cancellation is not received 24 hours before the scheduled appointment, a \$20 service charge will be billed directly to the patient for each cancellation. The \$20 service charge will be assessed prior to receiving services at the next visit.** We at Corvallis Sport and Spine Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is the necessary part of the treatment process. If you have any further questions, please do not hesitate to ask the office manager or your therapist. **Patients who fail to show up for appointments will be assessed the \$20 service charge and all appointments made in advance will be cancelled. The patient will only be allowed to schedule one visit in advance.**

I have reviewed this office policy statement and discussed it with the office manager or my therapist. All of my questions have been answered to my satisfaction and I understand all of the information as explained to me.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFIT, RELEASE OF INFORMATION AND CONSENT FOR TREATMENT

I, the undersigned, assign directly to Corvallis Sport and Spine Physical Therapy, Inc. all medical benefit, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I hereby authorize Corvallis Sport and Spine Physical Therapy, Inc. to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third party and that I may contact them with questions regarding my account.

I, the undersigned, voluntarily consent to physical therapy services at Corvallis Sport and Spine Physical Therapy, Inc. as ordered by my Physician and/or Therapist. I authorize Corvallis Sport and Spine Physical Therapy, Inc. to release my physical therapy records to my physician listed below.

Physician Name: _____

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____



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 IT CAREFULLY.

Corvallis Sport and Spine Physical Therapy, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

*“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with **Corvallis Sport and Spine Physical Therapy, Inc.**”*

*“It is our policy to provide a substitute health care provider, authorized by **Corvallis Sport and Spine Physical Therapy, Inc.** to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.”*

Payment

We may disclose your health information to our billing company and your insurance provider for the purpose of payment or health care operations.

*“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to **Corvallis Sport and Spine Physical Therapy, Inc.** for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide you with an itemized billing statement for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below:

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

*"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of **Corvallis Sport and Spine Physical Therapy, Inc.** sponsored fund-raising events."*

If you agree to receive our quarterly newsletter from E-Rehab, your personal health information will not be shared with E-Rehab and E-Rehab will not use your Email for marketing purposes.

Change of Ownership.

In the event that **Corvallis Sport and Spine Physical Therapy, Inc.** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **Corvallis Sport and Spine Physical Therapy, Inc.** is not required to agree to the restriction that you requested. **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.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **Corvallis Sport and Spine Physical Therapy, Inc.** amend your protected health information. Please be advised, however, that **Corvallis Sport and Spine Physical Therapy, Inc.** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **Corvallis Sport and Spine Physical Therapy, Inc.**
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Corvallis Sport and Spine Physical Therapy, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **Corvallis Sport and Spine Physical Therapy, Inc.** is required by law to comply with this Notice.

Corvallis Sport and Spine Physical Therapy, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Laura Hoffman, Privacy Officer by calling this office at 541-752-0545. If Laura Hoffman is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how **Corvallis Sport and Spine Physical Therapy, Inc.** has handled your health information should be directed to Laura Hoffman by calling this office at 541-752-0545. If Laura Hoffman is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01-01-2005

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **Corvallis Sport and Spine Physical Therapy, Inc.** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date