GREENRIDGE
Physical Therapy
& Wellness

Patient Information Form

Last Name: _____ First Name: _____
M.I.:_____

Please circle: Male Female
Married Single Other

Home address: _____
Mailing: _____
City: _____ State: _____
Zip Code:_____

Phone: (H) _____ (C) _____
(W) _____ (okay to call here (circle one)? Yes No
***Is it okay to leave detailed messages at home/cell (circle one)? Yes No**

E-Mail Address:
_____

Date of Birth: _____
Social Security# (*necessary for billing purposes): _____

Date of Injury: _____

***Work related (circle one)*: Yes No *Auto Accident (circle one)*: Yes No**

Referring Physician: _____
Date last seen: _____

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Authorization for Treatment

The undersigned authorizes the practitioners of Green Ridge Physical Therapy & Wellness to provide physical therapy and other therapeutic treatments deemed necessary for their care. It is understood that this type of therapy involves the use of "touch" for both assessment and treatment and that the therapist will explain these approaches to the patient and answer any questions regarding the procedures.

Authorization for Charges

The undersigned hereby accepts responsibility for all charges relating to services provided. Green Ridge Physical Therapy & Wellness will provide the service of billing physical therapy charges to the patient's insurance company, with benefits to be paid directly to Green Ridge Physical Therapy & Wellness. **The undersigned fully understands and agrees that they are financially responsible for all balances due. It is also understood that it is the responsibility of the undersigned to determine/confirm the physical therapy benefits that apply to their specific plan** (this includes but is not limited to: necessary doctor's written prescription/referral, deductibles, percentage pay out, co-pays, and yearly coverage maximums). **Any outstanding balances remaining after 60 days from the time of service will be subject to a 1.5% monthly interest charge (18% annually).** For any returned checks there will be an NSF assessment of $35.00. If balances are not paid within 90 days, and/or a plan of repayment has not been set up through contact from the undersigned with our billing office, the patient understands that there will be further action taken through assigning the outstanding account to an outside collection agency.

Cancellation Policy

The undersigned acknowledges understanding that there is a **24-hour cancellation policy** for a scheduled appointment, and that there may be a $65.00 fee charged for missed appointments not cancelled within that time frame. This amount is not billable to insurance companies and will be the full responsibility of the patient. Green Ridge Physical Therapy & Wellness will make every effort to fill an appointment and offset the fee if enough time is allowed. We do understand cases of illness and/or emergencies, and will take those instances into consideration.

Patient Signature (Guardian if patient is under 18) **Date Signed**

Printed Name of Patient

Green Ridge Physical Therapy
325 N. Locust Street / PO Box 1911 Sisters OR 97759
Phone 541 549 3534 Fax 541 549 1272

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

This authorization allows Green Ridge Physical Therapy & Wellness to discuss medical records and/or billing details with designated family members or other individuals. This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize my therapist and/or support staff at **Green Ridge Physical Therapy & Wellness** to discuss information related to my medical records and/or billing details with the following individuals:

Name:_____
Relationship:_____
Contact Phone Number:_____
Type of Inform to be released (**circle one or both**): **Records** **Billing**
Emergency Contact (circle one): **Yes** **No**

Name:_____
Relationship:_____
Contact Phone Number:_____
Type of Inform to be released (**circle one or both**): **Records** **Billing**
Emergency Contact (circle one): **Yes** **No**

The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of the signing or shall remain in effect for the period reasonably needed to complete the request.

_____
Printed name of patient

X_____
Signature of patient or person authorized by law.

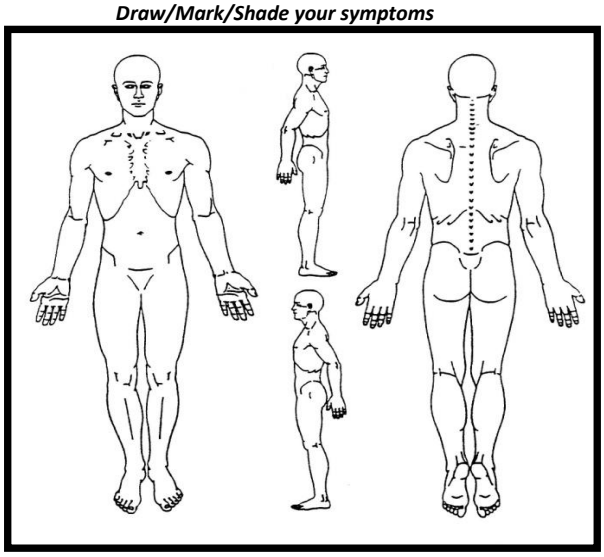
_____
Date Signed

325 N. Locust Street
(P.O. Box 1911)
Sisters, OR 97759
Phone: 541-549-3534 / Fax: 541-549-1272

Health History

Name:_____ Date:_____

Draw/Mark/Shade your symptoms



When did symptoms start?_____

Describe Symptoms:_____

_____

_____

_____

_____

_____

_____

_____

Have you had a similar issue before? Y or N

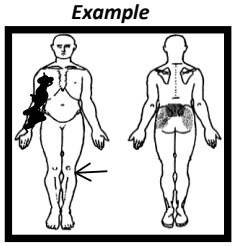
If so, what year(s)?_____

Surgery Date?_____

	0 = No Pain									10 = Worst Pain
Worst pain ----------	0	1	2	3	4	5	6	7	8	9	10
Current pain----------	0	1	2	3	4	5	6	7	8	9	10
Best pain----------	0	1	2	3	4	5	6	7	8	9	10

(Circle number for each line)

Example



How would you describe your symptoms? **(circle all that apply)**

Throbbing	Shooting	Numb	
Tingly	Weak	Constant	
Burning	Sharp	Dull / Achy	Other_____

What is your occupation?_____

Full time Part time Retired Unemployed Disabled Student Homemaker

Rate job activity level: ***(Mark line with an 'X')*** Sedentary [_____]Very Strenuous

What previous treatment have you had for this condition?_____

_____

What imaging or tests have you had for this condition?_____

_____

How would you describe your general health?_____

Are you currently able to drive?_____

What have you been *unable* to do because of this condition? What has been limited or modified?

_____

_____

What are your usual activities, hobbies, sports or exercise habits?_____

_____

How have they been effected by your condition?_____

_____

Have you traveled outside the country in the last 30 days?_____

Health Questionnaire

Name:_____ Date: _____

Have you recently experienced any of the following…..? Check the box if "YES"

- ☐ Falls or Near-falls
- ☐ Chest Pains
- ☐ Light-headedness
- ☐ Loss of Consciousness
- ☐ Night Sweats
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Swelling in Legs or Ankles
- ☐ Leg Cramps
- ☐ Fatigue

- ☐ Cauda Equina
- ☐ Lupus
- ☐ Current Infection
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Immune Suppression

- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Blood in Stools
- ☐ Heartburn / Indigestion
- ☐ Food Intolerances
- ☐ Difficulty Swallowing
- ☐ Change in Appetite
- ☐ Excessive Belching / Gas
- ☐ Change in Stools

- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Unexplained Weight Change

- ☐ Urinary Tract Infection
- ☐ Incontinence
- ☐ Painful Intercourse
- ☐ Painful Periods
- ☐ Erectile Dysfunction
- ☐ IUD Usage
- ☐ Prostate Problem

- ☐ Increased urinary frequency
- ☐ Night Pain
- ☐ Pain with Rest
- ☐ Fever / Chills /Sweats
- ☐ Trauma / Fall etc.
- ☐ Car Accident
- ☐ Prolonged Steroid Use
- ☐ Orthotic Use
- ☐ Short Leg
- ☐ Joint Replacement
- ☐ Osteo-arthritis

- ☐ Difficulty Breathing
- ☐ Productive Cough
- ☐ Dry Cough
- ☐ Asthma

- ☐ Balance Difficulties
- ☐ Muscle Weakness
- ☐ Vision Changes
- ☐ Hearing Changes
- ☐ Ringing in Ears / Tinnitus

- ☐ Speech Difficulties
- ☐ Memory Changes
- ☐ Psychiatric Care
- ☐ Confusion
- ☐ Dizziness
- ☐ Pins or Needles
- ☐ Headaches
- ☐ Migraines
- ☐ Tremors
- ☐ Seizures
- ☐ Depression

- ☐ Pregnancy
- ☐ Difficulty Urinating
- ☐ Pain w/ Urination
- ☐ Blood in Urine
- ☐ HIV / AIDS
- ☐ Sexually Transmitted Disease

- ☐ Polio
- ☐ Obesity
- ☐ Sleep Apnea
- ☐ Scoliosis
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Rheumatoid-arthritis
- ☐ Brain Injury

- ☐ Eating Disorders
- ☐ Addictions
- ☐ Skin Changes
- ☐ Slow Wound Healing
- ☐ Fibromyalgia
- ☐ Fracture(s)
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Hernia
- ☐ Cancer
- ☐ Huntington's Disease
- ☐ Muscular Dystrophy
- ☐ Heart Disease
- ☐ Stroke / CVA
- ☐ History of Tobacco Use
- ☐ History of Abuse
- ☐ Other:_____

_____

_____

_____

_____

Green Ridge Physical Therapy & Wellness - Patient Record

Patient Name _____ Date _____

	What I'm taking	Form (pill, injection, liquid, patch, etc.)	Dosage *How Much and When*	Use (regular or occasionally)	Start/Stop Dates (1/5/05 - 3/5/05) (1/5/05 - ongoing)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

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Workers Compensation Claim / PIP Claim Information

Workers Compensation Details:

Liability Carrier: _____

Claims Adjuster Name: _____ **Phone#:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Claim# _____

"Open Claim"- Yes No "Accepted Claim"- Yes No Date Verified: _____

Employer Benefits Contact: _____ **Phone#:** _____
Date of Accident: _____ **Location:** _____

Brief Description of Accident:

_____
_____
_____
_____
_____

PIP Claim Details:

Date of Accident: _____ **Location:** _____

Brief Description of Accident:

_____
_____
_____

Insurance Co: _____ **Phone##:** _____

Claims Adjustor Name: _____

Claims Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Policy# _____ **Claim#** _____

"Open Claim"- Yes No (Circle one) Date Verified: _____

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Notice of Privacy Practices/HIPAA

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

Green Ridge Physical Therapy and Wellness is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and abide by the terms of the notice that is currently in effect. "Protected health information" includes any identifiable health information that we obtain from you or others that relates to the past, present, or future healthcare and treatment or the payment for your healthcare or treatment. Healthcare information may include health history and status, test results, diagnoses, and physical therapy treatments. Green Ridge Physical Therapy and Wellness reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a copy of the most current privacy notice.

The following describes how the clinic is permitted to use or disclose your health information:
• The coordination or management of your health care, including contact with other health care providers directly related to your care • Activities for payment, including contact for eligibility for health plan or insurance coverage and submitting claims • Support for treatment and payment such as quality assurance and administrative duties• When required by federal, state, or local law• To avert a serious threat to health or safety.

Your Rights Regarding Your Health Information:
• You have the right to obtain a copy of the health information from the clinic• You have the right to submit in writing an amendment to the information about you if you believe the information is incorrect• You have the right to request a restriction or limitation of your information that we use or disclose about you, but we are may still be required to provide information to insurance company • You have the right to ask us to communicate with you at a special address or by a special means, if you believe that the disclosure of certain information could endanger you• You have a right to complain about our privacy practices, if you think your privacy has been violated• **You have a right to receive a paper copy of this notice**.

I have read and understand the information above:

NAME/ GUARDIAN:_____
SIGN NAME:_____
DATE:_____

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Sisters, OR 97759
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