Patient Case Information Summary

☐ #1 WC ☐ #2 No Ins ☐ #3 Ins ☐ #5 Medicare ☐ #7 MVA

Patient Name: (Last) _____ **(First)** _____
Guarantor's Name: (Last) _____ **(First)** _____
Address: _____ **City:** _____ **Zip:** _____
Home Telephone: (___)_____ **Cell Phone:** (___)_____ **Work Telephone:** (___)_____
DOB: ___/___/___ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ M ☐ S ☐ D ☐ W
Social Security Number: _____-___-_____ **Email Address:** _____
☐ I do not wish to be contacted via email by PT and Hand Clinic of Hillsboro, LLP
Accident: ☐ Yes ☐ No **Date of Injury:** ___/___/___
Employer: _____
Employer Address: _____ **City:** _____ **Zip:** _____

Referring Physician: _____ **Diagnosis:** _____
Primary Insurance: _____ **Telephone:** __(____)_____
Policy/Claim #: _____ **Group #:** _____ **Group Name** _____
Insured Name: ☐ Self ☐ Other: _____
Relationship to Insured: _____ **DOB:** ___/___/___

Secondary Insurance: _____ **Telephone:** __(____)_____
Policy Number: _____ **Group Number** _____ **Group Name** _____
Insured Name: ☐ Self ☐ Other: _____
Relationship to Insured: _____ **DOB:** ___/___/___

Emergency Contact Person: _____ **Telephone:** __(____)_____

How did you hear about us?
☐ Referring Physician ☐ Return Patient ☐ Family Member/Friend ☐ Internet
☐ Other: _____

Date of follow-up appointment with referring physician: ___/___/___ **Time:** _____

NOTES:

PHYSICAL THERAPY & HAND CLINIC OF HILLSBORO, LLP.

Debora A. Amara, MA, OTR/L

Physical Therapy & Hand Clinic of Hillsboro, LLP

Financial Policy Statement

Physical Therapy & Hand Clinic of Hillsboro will bill your insurance carrier out of courtesy and as a convenience for you. However, you are ultimately responsible for payment for the services you receive. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If payment for services is made directly to you, you must promptly remit the payment to our clinic. If your insurance company remits only a percentage of the total balance due, you will be responsible for the remainder of the balance. **Co-Pays are always due at the time of service.**

Consent for Treatment

I agree to give my consent for *Physical Therapy & Hand Clinic of Hillsboro* to furnish rehabilitation services considered necessary and proper in the treatment of my physical condition.

Authorization for Use/Disclosure of Health Information and Medical Records

I authorize *Physical Therapy & Hand Clinic of Hillsboro* to use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information. Copies of the physical therapy record and billing statements will be forwarded to your insurance company for the purpose of billing for the services rendered.

Cancellation/No Show Policy

The appointments made represent time set aside specifically for you. All cancellations should be made at least 24 hours prior to the scheduled visit except in case of illness or emergency. Patients who cancel or no show on three separate occasions without good cause will be allowed to schedule additional appointments **ONLY** at the discretion of the treating therapist. **By law, all cancellations and no shows involving worker's compensation claims must be reported to your physician, your claims adjuster, and worker's compensation insurance carrier.**

I understand and agree to the *Financial Policy Statement, Consent for Treatment, Authorization for Use/Disclosure of Health Information and Medical Records,* and the *Cancellation/No Show Policy* above:

Patient/Guardian: _____ **Date:** ___/___/___

Signature

Print Name: _____

620 SE OAK ST SUITE A HILLSBORO OR 97123 (P)503.844.6565 (F)503.844.4225
www.pthandclinic.com (E) ptandhand@gmail.com

Physical Therapy and Hand Clinic of Hillsboro, LLP

PATIENT MEDICAL HISTORY

Name:_____Physician:_____

Attorney (if applicable)_____ _____Attorney's Telephone:_____

Please list any surgeries you have had for this injury:

_____

_____

Are you allergic to any medications? YES ____NO____

List medications:

_____

_____

Have you had any of the following medical or rehabilitative services for this injury/episode?'

___ Physical Therapy
___Occupational Therapy
___Chiropractic
___Emergency Room Care
___Massage Therapy
___Acupuncture

___X-Rays
___CT Scan
___ MRI
___ Bone Scan

Do you now have or have you ever had any of the following?

___Asthma, Bronchitis, or Emphysema
___Shortness of Breath/Chest Pain
___Coronary Heart Disease or Angina
___High Blood Pressure
___Heart Attack or Heart Surgery
___Stroke
___Congestive Heart Failure
___Blood Clot/Emboli
___Epilepsy/Seizures
___Thyroid Disease or Goiter
___Anemia
___Infectious Disease
___Diabetes
___Cancer
___Arthritis
___Osteoporosis
___Gout
___Sleeping Problems
___Emotional Problems

___Severe or Frequent headaches
___Visual or Hearing Difficulties
___Dizziness or Fainting
___Bowel or Bladder Problems
___Weakness
___Weight Loss/Energy Loss
___Hernia
___Varicose Veins
___Allergies
___Any pins or metal implants
___Shoulder Injury or Surgery
___Neck Injury or Surgery
___Joint Replacement Surgery
___Elbow/Hand Injury or Surgery
___Back Injury or Surgery
___Knee Injury or Surgery
___Leg/Ankle Injury or Surgery
___Are you Pregnant
___Use Tobacco

Please list any other information that you believe would assist the therapist in your care:

_____

_____

Are you aware of your diagnosis and prognosis as explained by your doctor? ____YES ____NO

What are your rehabilitation expectations and goals while in this program?

_____

Patient/Guardian Signature _____Date:_____

Medicare Questionnaire

Medicare requires this form to be completed by all Medicare patients. Please read each of the following and respond ONLY to those that apply to your current situation.

Patient Name: _____ HIC # _____

1. If you have received home health care I the past 60 days, please provide us with the name and telephone number of the home health agency.

   _____

2. If you are entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program, please provide the name, address, and phone number for that program. _____

   _____

   The government program will be primary to Medicare.

3. Was your illness or injury due to any of the following:
   ☐ Work ☐ Auto Accident ☐ Accident on property other than your own, i.e. store, restaurant, etc.
   Date of your Accident if one of the above: ___/___/___
   Details of your accident: _____

   _____

   _____

   Liability Insurance Information for the above accident: _____

   _____

   Medicare requires us to file with the above liability insurance first.

4. Do you feel that you have the right to be compensated by a party who may have Caused the injury or illness ? ☐ Yes ☐ No

5. If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness ? ☐ Yes ☐ No If Yes, please provide your attorney's name, address, and phone: _____

   _____

6. If you have received a kidney transplant or are receiving dialysis for End Stage Renal Renal Disease, please give the date of the transplant or start of dialysis. ___/___/___
   If the date is less than 18 months ago, are you currently covered under group insurance provided by your employer or a family member's employer ?
   ☐ Yes ☐ No

7. If none of these apply to you and your Medicare coverage is due to age or disability, Do you have group health coverage through your employer or a family member's employer ? ☐ Yes ☐ No

If you answered YES to questions #6 or #7 above, please provide your group health Insurance information:

Name: _____
Address: _____
Telephone: _____
Employer's Name: _____

Patient Signature:_____ Date___/___/___