

Patient Registration Form

West Portland
Physical Therapy
Clinic LLC



Patient Information

Name:		Account # :
Address:		Phone:
Email:		Date of Birth:
		May we contact you via email? Yes No

Employer Information

Employer:	Employer Phone:
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Guarantor Information

Guarantor Name:	Guarantor Phone:
Guarantor Address: (If different from patient):	

Emergency Contact Information

Emergency Contact:	Emergency Contact Phone:
Relationship:	

Injury Information

Date of Injury:	Onset Date:	Work Related?	Auto Related	Account Type:
			- State -	-
Description of Injury:				

Physician Information

Referring Physician:	Phone:
Primary Physician:	Phone:
Other Physician:	Phone:

Primary Policy Information

Name/Address of Insurance	Policy / ID #	Group #	Name of Insured	Insured DOB
			Effective Dates	-

Secondary Policy Information

Name/Address of Insurance	Policy / ID #	Group #	Name of Insured	Insured DOB
			Effective Dates	-

I certify that all of the information provided herein is true and correct.

Signature: _____ Date: _____



Name: _____	Date of Birth: _____
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NOTIFICATION OF PATIENT RESPONSIBILITY

West Portland Physical Therapy Clinic, LLC ("WPPTC") verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization, or network plan. We request that you check with your health plan for a complete understanding of what will be billed to you.

If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment for services.

Based upon the information that your insurance company quoted to us, your benefits are as follows:

Deductible:	\$	Co-Insurance:	%	Co-Payment:	\$
Benefit Description: _____					

FINANCIAL RESPONSIBILITY and ASSIGNMENT OF BENEFITS

I understand that insurance billing is provided as a courtesy and that I am financially responsible to West Portland Physical Therapy Clinic, LLC for all charges arising from my treatment. It is my responsibility to notify WPPTC of any changes in my health care coverage. While WPPTC verifies benefits with my health plan, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies received by me.

I authorize direct payment from my health insurance plan to WPPTC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

CANCELLATION POLICY

We are entering into a cooperative partnership with you and your physician to help you attain your maximal rehabilitation goals. We understand that circumstances may arise requiring you to cancel your scheduled appointment. However, cancellations have a serious impact on the clinic. If you need to cancel an appointment on Monday, you must notify us by 4:00 pm on Friday to avoid the cancellation fee.

A \$35.00 fee will be charged to your account if you cancel with less than 24 hours notice.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for WPPTC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

CONSENT FOR TREATMENT and RELEASE OF INFORMATION

I am aware of my diagnosis and wish to receive treatment from WPPTC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to WPPTC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize WPPTC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I certify that I have read this agreement and my signature indicates my understanding and consent.

Signature: _____ **Date:** _____



Name: _____

Date of Birth: _____

It is very important for us to stay in touch with your physician. Please provide us with the date of your next appointment.

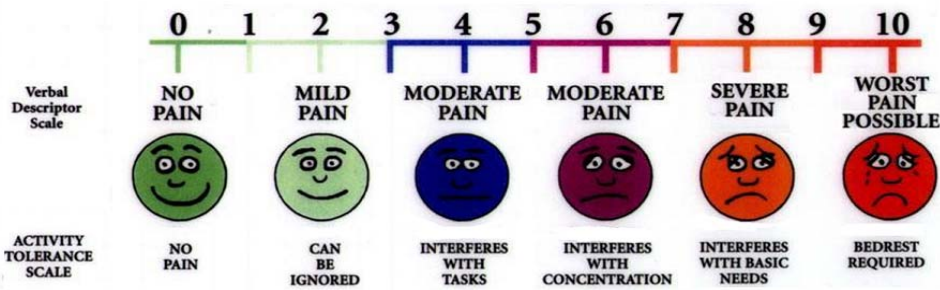
Next Physician Appointment: _____

Today's Date: _____

If you do not have an appointment set, please let us know when you have made your next appointment.

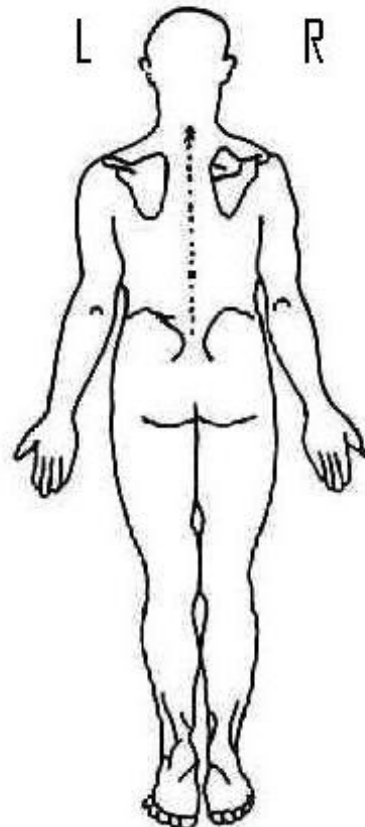
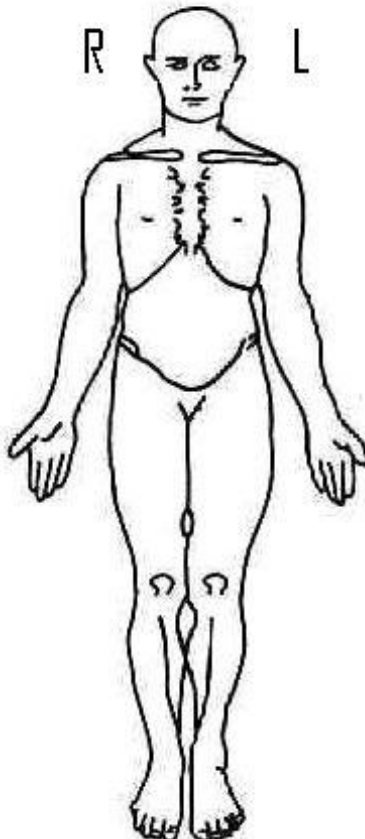
UNIVERSAL PAIN ASSESSMENT TOOL

Please Circle the Description of your pain in the past week. Circle both your best level of pain and your worst level of pain.



WHERE IS YOUR PAIN?

Please mark the area of your pain on the drawings below.



Medical History

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Name: _____

Date of Birth: _____

Occupation: _____ Age: _____

Referring Physician: _____ Primary Physician: _____

Have you had surgery for this injury? Yes _____ No _____ Type _____ Date: _____

Please list current medications:

Anti-inflammatories: _____

Muscle Relaxers: _____

Pain Medication: _____

Other: _____

Have you seen or had any of the following for your current complaint: (Check if yes)

Primary Physician	_____	Massage Therapy	_____	CT Scan	_____
Neurologist	_____	Accupuncture	_____	EMG	_____
Orthopedist	_____	X-Rays	_____	Bone Scan	_____
Physical Therapist	_____	MRI	_____	Other	_____

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

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	_____	_____	Cancer	_____	_____
Shortness of Breath / Chest Pain	_____	_____	Arthritis	_____	_____
Heart Disease or Angina	_____	_____	Stroke / TIA	_____	_____
Heart Attack or Surgery	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Gout	_____	_____
Do You Have a Pacemaker?	_____	_____	Anemia	_____	_____
Blood Clot or Emboli	_____	_____	Allergies	_____	_____
Infectious Diseases	_____	_____	Osteoporosis	_____	_____
Vision or Hearing Problems	_____	_____	Hernia	_____	_____
Thyroid or Goiter Trouble	_____	_____	Weakness	_____	_____
Numbness or Tingling	_____	_____	Ear Ringing	_____	_____
Dizziness or Fainting	_____	_____	Weight Loss	_____	_____
Metal in Body or Surgical Implants	_____	_____	Weight Gain	_____	_____
Joint Replacement	_____	_____	Neck Injury	_____	_____
Sleeping Problems or Difficulties	_____	_____	Back Injury	_____	_____
Bowel or Bladder Problems	_____	_____	Knee Injury	_____	_____
Emotional / Psychological Problem	_____	_____	Hand Injury	_____	_____
Do You Smoke?	_____	_____	Elbow Injury	_____	_____
Are you currently pregnant?	_____	_____	Shoulder Injury	_____	_____
			Ankle or Foot Injury	_____	_____

Please list any past surgeries that you have had and the date:

Are you aware of your current diagnosis? Yes _____ No _____

What are your expectations and goals of treatment?

Signature: _____ Date: _____

Men's Health / Pelvic Floor Questionnaire

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Name: _____	Date of Birth: _____
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Please circle the number below which applies to your symptoms over the past month:

	Never	Moderate		Severe	
Pain in the rectum.....	0	1	2	3	4
Pain in the groin or lower abdomen.....	0	1	2	3	4
Pain in the buttocks.....	0	1	2	3	4
Pain in the testicles.....	0	1	2	3	4
Pain in the penis.....	0	1	2	3	4
Prostate pain.....	0	1	2	3	4
Pain in the sacrum or low back.....	0	1	2	3	4
Pain during or following intercourse.....	0	1	2	3	4
Pain with sitting.....	0	1	2	3	4
Pain with urination.....	0	1	2	3	4

List any other activities that increase your pain in the pelvic region:

- Do you have difficulty getting or maintaining an erection? NO YES
- Do you experience urinary incontinence? NO YES
- If you are wearing pads for protection how many do you wear a day? _____
- Do you use any other form of protection, and if so what? _____
- Do you experience urinary urgency? NO YES
- On average how many times do you urinate during the day? _____
- On average how many times do you urinate at night? _____
- Do you have difficulty stopping the flow of urine? NO YES
- Do you have difficulty starting the flow of urine? NO YES

Consent Form Internal Pelvic Floor Evaluation

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Name: _____

Date of Birth: _____

In order to fully understand the scope of your individual diagnosis there is some very important information your therapist needs.

Please be brief in your answers. If your physical therapist needs you to expand upon your answers she will ask you privately.

- | | Yes | No |
|--|--------------|--------------|
| 1. Are you currently sexually active?
If "no", have you been sexually active in the past? | ____
____ | ____
____ |
| 2. Do you have any communicable diseases?

If yes, please describe _____ | ____ | ____ |
| 3. Has there been any sexual abuse in your past | ____ | ____ |
| 4. Have you had difficulty with past vaginal exams? | ____ | ____ |

I give / deny my consent for my therapist to do a rectal examination for the purpose of evaluating my condition and
(please circle)
determining therapeutic treatment.

1. I understand that I can terminate the procedure at any time.
2. I understand that I am responsible for immediately telling my physical therapist if I am having any discomfort or unusual symptoms during the procedure.
3. I have the option of having a second person present in the room during this procedure and I refuse / choose this option.
(please circle)
4. I have read this consent form and understand its terms.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____