Patient Registration Form

West Portland
Physical Therapy
Clinic LLC

Patient Information

		Account # :	
Name:		Date of Birth:	
Address:		Primary Phone:	
Please indicate the best number for your appointment reminder calls: ☐ Home ☐ Cell ☐ Text		Alternate Phone:	
Email:		May we contact you via email? Yes No	

Employer Information

Employer:		Employer Phone:	

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:				
Is this injury related to a Motor Vehicle Accident?	Yes No	Is this injury related to a Workers Comp claim?	Yes No	

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: __________

Therapist Initials: _______

Patient Consent Form

West Portland Physical Therapy Clinic LLC

Name:		**Date of Birth:**	

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*:**	$
Primary Benefit:					
Secondary Benefit:					

*After deductible is met.

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 rehabilitation goals. We understand that circumstances may arise requiring you to cancel your scheduled appointment. **A $100 minimum appointment fee, which you are financially responsible for, will be charged to your account if you cancel or reschedule with less than 24 business hours' notice.** If you need to cancel an appointment on Monday, you must notify us by **5:00pm on Thursday** to avoid the cancellation fee.

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: __________

Pain Assessment

West Portland
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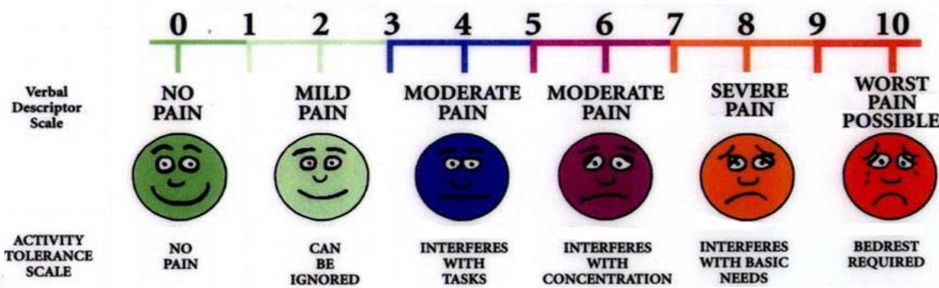
Name:		Date of Birth:	

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

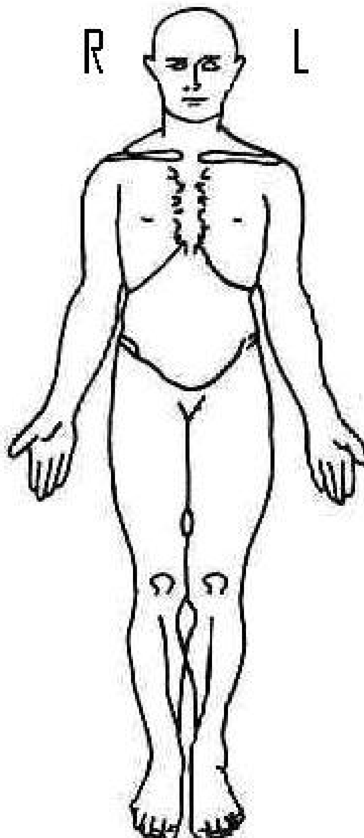
Next Physician Appointment: ______________________ Today's Date: ______________

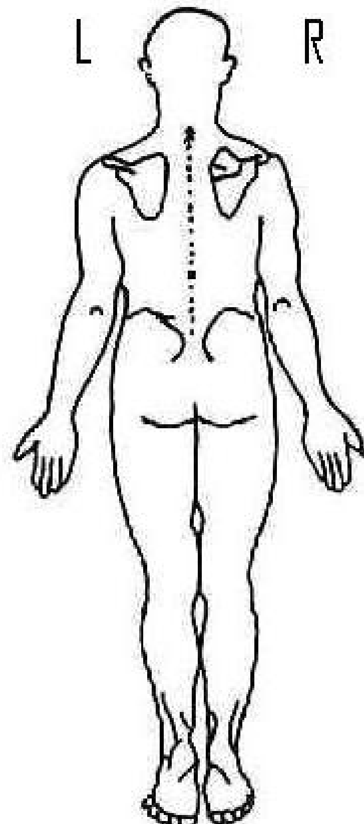
If you do not have an appointment set, please let us know when you have made your next appointment.



WHERE IS YOUR PAIN?

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





Medical History

West Portland
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Clinic LLC

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 other practitioners or had any of the following treatments for your current complaint?

Orthopedist	____________________	Massage Therapy	____
Neurologist	____________________	Acupuncture	____
Physical Therapist	____________________	X-Rays	____
Chiropractor	____________________	MRI	____
Naturopath	____________________	Other	____

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

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	____	____	Diabetes	____	____
Shortness of Breath / Chest Pain	____	____	Gout	____	____
Heart Disease or Angina	____	____	Anemia	____	____
Heart Attack or Surgery	____	____	Hernia	____	____
High Blood Pressure	____	____	Neck Injury	____	____
Do You Have a Pacemaker?	____	____	Back Injury	____	____
Blood Clot or Emboli	____	____	Knee Injury	____	____
Infectious Diseases	____	____	Hand or Wrist Injury	____	____
Numbness or Tingling	____	____	Elbow Injury	____	____
Dizziness or Fainting	____	____	Shoulder Injury	____	____
Metal in Body or Surgical Implants	____	____	Ankle or Foot Injury	____	____
Joint Replacement	____	____	Do you smoke?	____	____
Sleeping Problems or Difficulties	____	____	Are you currently pregnant?	____	
Bowel or Bladder Problems	____	____	Are you allergic to latex?	____	
Emotional / Psychological Problem	____	____	Unexplained Weight Loss / Gain	____	
Osteoporosis	____	____	Is your pain relieved by rest or bed rest?	____	
Arthritis (Rheumatoid)	____	____	Do you have a history of cancer?	____	
Stroke / TIA	____	____	(especially breast, prostate, or lung cancer)		

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

West Portland
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Name:		Date of Birth:	

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

Are you wearing pads / diapers for protection? .... NO YES
(please circle)

If so, 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

West Portland
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Clinic LLC

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	____	____

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: ____________________