Patient Information

Please download or print forms before filling out.
Bring the day of your appointment, or email ahead of time to rodeptbend@gmail.com

First name | MI | Last name

Street address

City | State | Zip

Phone | Email | Date of birth

Emergency contact

Phone | Email

Employer and occupation

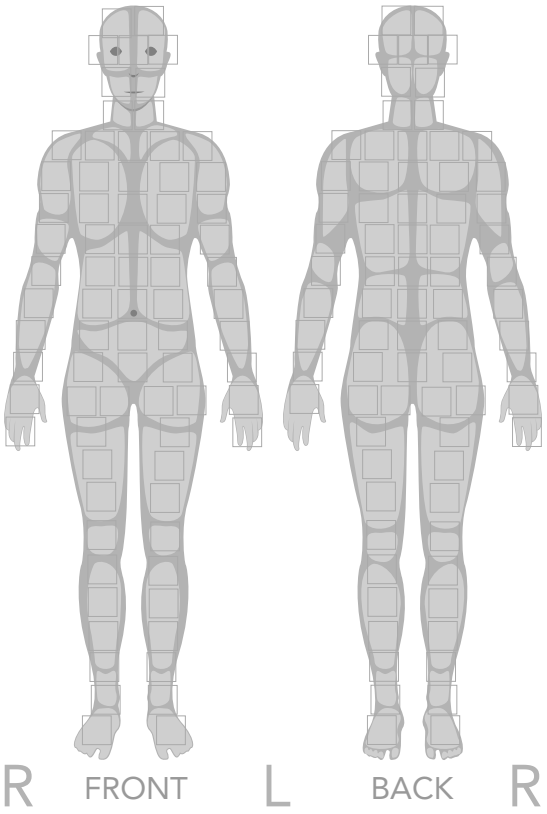
Primary care provider | Phone

Physician/specialist's name | Diagnosis

Insurance co. | Policy# | Group#

Insured's name

Use this chart to indicate pain site(s).



Patient Information

Patient's name

What body part are you seeking treatment for today? (example: neck, upper back, lower back)

Date of onset

Did you have surgery? yes ◯ no ◯

Date of surgery

Type of surgery

Surgeon/referring provider

Have you had this problem before? yes ◯ no ◯

Symptoms

Have you had previous treatments for this? yes ◯ no ◯ If so, please list with approx. dates (mo/year)

Please list all previous surgeries with approx. dates (mo/year)

Please list any X-rays, MRIs, CT scans or other imaging

Please list any additional musculoskeletal injuries (existing and past)

Patient Signature

Date Signed

Patient Information

Patient's name

What is your goal for therapy at this time?

What is your job/vocation?

List any activities that increase your pain (on the job/hobbies)

Do everyday activities increase pain (stairs, reaching overhead)? Describe your symptoms

Does anything help to reduce your symptoms?

Do you have pain that keeps you up at night? yes ◯ no ◯

Rate your highest pain level (0 lowest - 10 highest) in the past 24 hours Are you pregnant? yes ◯ no ◯

Are you taking any medications? yes ◯ no ◯ Please list

Are you allergic to any medications? yes ◯ no ◯ Please list

Please check if you have been diagnosed with any of the following conditions:

- ☐ Cancer (year/type)
- ☐ Urinary frequency
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Bowel/bladder change
- ☐ Stroke
- ☐ Recent weight loss/gain (10lbs)
- ☐ Vision/hearing loss
- ☐ Heart condition
- ☐ Hyper-thyroid disease
- ☐ Anxiety
- ☐ High blood pressure
- ☐ Autoimmune disease
- ☐ Hypo-thyroid disease
- ☐ HIV/AIDS
- ☐ Blood disorder
- ☐ Depression
- ☐ Diabetes
- Other:

Patient Signature Date Signed

Notice of Privacy Practices

Patient's name

This notice describes how medical information about you may be used and disclosed and how to obtain access to this information.

Uses and disclosures of your protected health information (PHI):

Treatment: With your agreement your information will be disclosed to additional healthcare providers involved in your care.

Payment: Includes the disclosure of your PHI for payment to insurance companies. Insurance companies occasionally require information regarding your physical therapy treatment to determine that your treatment was medically necessary.

Appointments and services: Includes the use of your email address and phone number for appointment reminders or information about your treatment.

Other uses and disclosures permitted/required by law:

- Public health activities, such as required reporting of disease, injury, birth and death or required pubic investigation
- If we receive reports of abuse, neglect or domestic violence
- To the Food and Drug Administration to report adverse events, product defect/recalls
- To your employers when we provide care to you at the request of your employer
- To a government agency conducting audits, investigations, civil or criminal proceedings.
- Court subpoena or \aw enforcement officials as required by law
- To funeral directors/coroners as consistent with law
- To worker compensation agencies for benefit determination

Your Privacy Rights:

You have the right to request restrictions on use and disclosures of your PHI for treatment or payment. We will attempt to accommodate reasonable requests when appropriate.
If you believe your privacy rights have been violated, you can file a complaint without retaliation. If you have questions or need further assistance regarding this notice you may contact us at 541-797-6104.

The signature below certifies that I have read and understand the above information.

Patient Signature

Date Signed

Patient Authorization

Patient's name

Release of information and consent for treatment:
I am aware of my diagnosis and wish to receive treatment at Rode Physical Therapy. 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 and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Rode Physical Therapy and affiliates to release information, verbal and written, contained in my medical record and other related information to my insurance company, case manager, attorney, employer, school, healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided. I authorize Rode Physical Therapy and/or its subsidiaries/affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

Initial

Notice of privacy practices (HIPAA acknowledgment/consent):
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Rode Physical Therapy, its subsidiaries and/or affiliates. 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.

Initial

Cancellation/no-show policy:
Please note that once you have booked an appointment with us it means that we have reserved time in our schedule exclusively for you. If you cancel your appointment less than 24 hours before it is scheduled to take place or you no-show your scheduled appointment, you will be subject to a fee of $50.00. To avoid any cancellation fees, please provide a cancellation notice of at least 24 hours prior to your visit. You can cancel or reschedule an appointment by emailing us at rodeptbend@gmail.com or calling our office at (541) 797-6104.

Initial

Assignment of benefits:
I authorize payment directly to Rode Physical Therapy, its subsidiaries and/or affiliates for services. 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.

Initial

Payment guarantee:
I agree to pay Rode Physical Therapy, its subsidiaries and/or affiliates for the services provided to me or the party named above. 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. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. Benefit verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage I will be responsible for payment for services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Rode Physical Therapy and/or its affiliates or subsidiaries.

Initial

The signature below certifies that I have read and understand the above information.

Patient Signature

Date Signed