

"Let's change your World."



Phone: (541) 535-2551
Fax: (541) 535-1417

Email: painhelp@turningpointpt.com
Web: www.turningpointpt.com

296 South Pacific Highway
(Hwy 99 North)
Talent, Oregon 97540

CONFIDENTIAL & PRIVATE INFORMATION

This cover sheet may be used as a FAX Cover.

FROM: _____

NUMBER OF PAGES: _____

DATE: _____

YOUR CONTACT PHONE: _____

NOTES: _____



Welcome to Turning Point Physical Therapy! Your therapy experience is very important to us and we will strive to deliver your services in a professional and enjoyable manner. Please read the following office policies thoroughly. **Paperwork must be completely filled out before your scheduled appointment time or the provider will not be able to see you.**

Thank You.

- **Appointment Policy:**

If your must cancel or reschedule an appointment, please notify the physical therapy office **at least 24 hours in advance.** ***One exception for unpredictable circumstances will be allowed.*** Missed appointments are costly to our practice and deprive other patients of the opportunity to receive care. A \$50.00 fee will be assessed, prior to continued treatment, for failure to properly reschedule or cancel a therapy appointment. Your attention to this matter is most appreciated.

- **Late Arrivals To Appointments**

If you are going to be late for a scheduled appointment please contact our office. In the event you are 15 minutes late or more, we may or may not be able to see you. This will be left up to the discretion of the physical therapist, however, if you are seen the appointment time will be reduced to allow for the time you were late.

- **Financial Policies:**

Insurance: We will try to provide an explanation of your insurance benefits; however, it is ultimately **your** responsibility to verify coverage. **IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR OTHER BALANCE LEFT UNPAID BY YOUR INSURANCE COMPANY.**

***Medicare Patients:** *Medicare now requires that patients in a physical therapy program must be seen by their prescribing physician every 60 days from the time you start therapy. It is your responsibility to schedule these appointments with your doctor.*

***Motor Vehicle Insurance:** As a courtesy, we will bill your MVA insurance company. Persons involved in a **LITIGATED SUIT** will **be expected to make payments** on any balance they may accumulate while being treated at this facility.

***Co-Pay Policies:** If your policy involves a co-payment, the amount of the co-payment **must** be made at the time of service.

***Fees:** Services and fees are available by contacting our billing department at (541) 535-2551.

- **There is a \$10.00 fee for copying of Medical Records for patient's private use.**

- **Medical Record Review with patient is provided for a cost of \$25.00 per/hour.**

***Child Care:** Please make arrangements for child care and pets. Children and pets are not allowed in the therapy department due to potential disruption of care and safety considerations.

I HAVE READ AND UNDERSTAND THIS POLICY STATEMENT AS SET FORTH AND AGREE TO FOLLOW THE PROCEDURES AS OUTLINED.

Signature: _____ Date: _____

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Today's Date: ____/____/____

Patient Legal Name: _____
Last First Middle

Birthdate: ____/____/____ SSN: ____-____-____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Employment Status: Full Time / Part Time / Retired / Unemployed / Disabled

Employer: _____

Employers Address: _____

City: _____ State: _____ Zip Code: _____

Employers Phone Number: (____) _____ - _____

Student Status: Full Time / Part Time / NA

Marital Status: Married / Single / Legally Separated / Divorced / Widowed

Name of Spouse: _____

Emergency Contact: _____ Phone Number: (____) _____ - _____

Referring Doctor: _____ Phone Number: (____) _____ - _____

Primary Doctor: _____ Phone Number: (____) _____ - _____

Billing Information:

Is this appointment the result of an accident or injury? _____ YES _____ NO

Circle One: Motor Vehicle / Workers Compensation / Personal Injury

Date of Injury: ____/____/____ Policy #: _____

Adjustor/Agent Name: _____

Phone Number: (____) _____ - _____ Ext: _____

Insurance Company Name: _____

Claims Address: _____

City: _____ State: _____ Zip Code _____

Employer: _____

TURNING POINT PHYSICAL THERAPY
296 SOUTH PACIFIC HWY.
TALENT, OREGON 97540
Phone: 535-2551 Fax: 535-1417

PAST MEDICAL HISTORY

NAME: _____ DATE: _____

Do you have an advanced directive? _____

1. What are your symptoms? _____
2. Was the onset of this episode? Gradual _____ Sudden _____
3. When was the onset of your symptoms? _____
4. How long have your symptoms lasted? A week or less _____
1-8 weeks _____ 3 months to a year _____ More than a year _____
5. Which one of the following best describes how your injury occurred?
Lifting _____ Car accident _____ A fall _____
Trauma/accident _____ Degenerative process _____ Overuse trauma _____
Running _____ Blow to the face _____ Sports injury _____
Throwing _____ Hit by a ball _____ Unknown _____
Other (explain) _____
6. Since the onset, are your symptoms getting?
Worse _____ Better _____ No change _____
7. How many times have you had similar symptoms to your current problems in the past? None Previously _____ 1-5 Episodes _____ 5+ _____
8. Have you ever had an operation? Yes _____ No _____ Have you ever had a surgery associated with your current symptoms? Yes _____ No _____
9. Nature of pain, check all that apply: Sharp _____ Dull _____ Throbbing _____
Aching _____ Periodic _____ Occasional _____ Constant _____ Other _____
10. Have you ever been diagnosed with any of the following? Check all that apply
Cancer _____ Osteoarthritis _____ Depression _____
High blood pressure _____ Hepatitis _____ Stroke _____
Tuberculosis _____ Emphysema _____ Anemia _____
Kidney Disease _____ Chemical dependency _____ Diabetes _____
Anorexia bulimia _____ Thyroid problems _____ Epilepsy _____
Raynauds disease _____ Multiple Sclerosis _____ Allergies _____
HIV/ AIDS _____ Rheumatoid Arthritis _____ Bronchitis _____
Heart problems _____ Bronchitis _____ Other _____

11. Has anyone in your immediate family ever been treated for the following?

Check all that apply

Cancer _____	Arthritis _____	Mental Illness _____
High blood pressure _____	Hepatitis _____	Stroke _____
Tuberculosis _____	Emphysema _____	Anemia _____
Kidney Disease _____	Chemical dependency _____	Diabetes _____
Epilepsy _____	Heart problems _____	Other _____

12. Are you currently seeing any of the following? Check all that apply

Osteopath _____	Psychiatrist/Psychologist _____
Dentist _____	Chiropractor _____

13. What are your current symptoms? Check all that apply

Fever/chills/sweats _____	Syncope _____	Night pain _____
Malaise _____	Dyspnea _____	Bowel dysfunction _____
Nausea/vomiting _____	Numbness _____	Sexual dysfunction _____
Weakness _____	Dysuria _____	Dizziness _____
Light headaches _____	Urinary frequency changes _____	
Unexplained weight change _____		

14. Please list any prescriptions, medications, over the counter drugs you are taking including pills, injections, skin patches, etc. _____

15. How many packs of cigarettes do you smoke per day? _____

16. How many caffeinated drinks (coffee, soda pop) do you drink per day? _____

17. How many alcoholic drinks per day do you consume? _____

18. How many days per week do you drink alcohol? _____

19. How many days per week do you smoke marijuana? _____

20. Do any of the following increase your symptoms/pain? Check all that apply

Walking _____	Work _____	Personal care _____	Sleeping _____
Dressing _____	Stairs _____	Reaching _____	Sitting _____
Carrying _____	Reading _____	Driving _____	Recreation/sports _____
Headaches _____	Lifting _____	Talking _____	Concentration _____
Standing _____	Eating _____	Squatting _____	Uneven ground _____

21. Do you feel hot and cold sensations? Yes ___ No ___

22. If no, where do you experience the absence of feeling these sensations?

FINANCIAL RESPONSIBILITY DISCLAIMER

Name: _____ Date: _____

Phone Number: _____ Referring Dr.: _____

We are happy to bill your insurance. ***However, you are responsible for contacting your insurance to clarify you individual coverage for physical therapy.*** Some insurance companies limit the number of physical therapy visits in a given year. If this is the case, please notify your therapist so that your program can be designed to fit into these limitations. Also, you must keep track of your visits so you don't exceed the parameters (number of visits allowed per calendar year or per year). ***If payment is denies for too many visits, you are responsible for those charges.***

If you have any questions, please discuss them with us. It is our goal to provide you a program that is both successful for your physical needs and financial restrictions and responsibilities.

I acknowledge that it is my responsibility to verify insurance coverage with my insurance company. I understand that I am financially responsible for any charges incurred with my physical therapy in the event that my insurance company fails to cover any charges.

PATIENT SIGNATURE: _____ **DATE:** _____

(FOR OFFICE USE ONLY)

INSURANCE: _____ POLICY: _____

INSURANCE PHONE #: _____

EFFECTIVE DATE: _____ DX: _____

RX MD ONLY PRE-AUTH REFERRAL REQUIRED

PRE-AUTH#: _____ REFERRAL #: _____

DED AMOUNT: _____ MET: YES NO

CO-PAY: _____ COINSURANCE _____

VISIT LIMIT YEARLY TOTAL: _____

TURNING POINT PHYSICAL THERAPY
296 SOUTH PACIFIC HWY.
TALENT, OREGON 97540
Phone: 535-2551 Fax: 535-1417

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Turning Point Physical Therapy to use and disclose the health and medical information of

_____ for the purposes of Treatment, Payment and Health Care Operations.

(Name of Patient)

- **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any health care professional who covers my/our practice by telephone as the on call provider).
- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).
- **Health Care Operations** (includes the necessary administrative and business functions of our office).

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Turning Point Physical Therapy has already used or disclosed the information in reliance on this CONSENT.

(Date)

(Signature of Patient)

(or)

(Date)

(Signature of Representative)

(Description of representative's authority)

Notice of Privacy Practices

TURNING POINT PHYSICAL THERAPY, LLC
PRIVACY OFFICER: MIKE PENNINGTON: 541.535.2551

Effective Date: February 2, 2006

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How this Medical Practice May Use or Disclose Your Health Information	p. 2
B. When This Medical Practice May Not Use or Disclose Your Health Information	p. 4
C. Your Health Information Rights	p. 5
1. Right to Request Special Privacy Protections	
2. Right to Request Confidential Communications	
3. Right to Inspect and Copy	
4. Right to Amend or Supplement	
5. Right to an Accounting of Disclosures	
6. Right to a Paper Copy of this Notice	
D. Changes to this Notice of Privacy Practices	p. 6
E. Complaints	p. 6

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under Oregon law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers [health care clearinghouses] [and health plans] who participate in any organized health care arrangement for which Regional Cardiology Medical Associates physicians participate.

4. Appointment Reminders/Test Results. We may use and disclose medical information to contact and remind you about appointments and/or to inform you of your test results. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may also send you appointment reminder notices on a post card.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Oregon law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Oregon law. We may deny your request under limited circumstances. If

we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

TURNING POINT PHYSICAL THERAPY, LLC

PRIVACY OFFICER: MIKE PENNINGTON 541.535.2551

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

Reasons for refusal:
