

"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

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 you 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 Appointment:** If you are going to be late for a scheduled appointment please contact our office. In the event you are 15 minutes or more, we 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 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-pay **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

Birthday: ___/___/___

SSN#: ___/___/___

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Employment Status: Full time/ Part Time/ 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# (____) _____ - _____

Referring Doctor: _____

Primary Doctor: _____

Turning Point Physical Therapy

296 S. Pac. Hwy.

Talent, OR. 97540

Phone: 541-535-2551

Fax: 541-535-1417

Web: www.turningpointpt.com

Email: painhelp@turningpointpt.com

MEDICAL HISTORY

Name: _____ Date: _____

1. Do you have an advanced directive? YES / NO
2. Onset date? (date within last 6 month of the issue or symptoms worsening) _____
3. Primary diagnosis? (Worst complaint you are here for...) _____
4. Medications? (Please list any prescriptions, medications, over the counter drugs you are taking including skin patches, ect. _____
5. Physician? (Practitioner who sent you to physical therapy) _____
6. Occupation? _____
7. Age? _____ D.O.B. ____/____/____
8. Gender? M/F
9. Mechanism of injury: (Please check one or explain 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 _____

10. What are your current symptoms? (Check all that apply and write-in if needed)

Pain ____ Mechanical pain ____ Pins and needles ____
Fever/chills/sweats ____ Syncope ____ Night pains ____
Malaise ____ Dyspnea ____ Bowel dysfunction ____
Nausea/vomiting ____ Numbness ____ Sexual dysfunction ____
Weakness ____ Dysuria ____ Dizziness ____
Headaches ____ Urinary frequency changes ____
Unexplained weight changes ____ other _____

11. Other diagnosis? (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 ____ other (write-in) _____

12. Age of condition? _____

13. Have you had Physical Therapy before? Y/N

14. Practitioners seen for this condition? (Check if applicable)

Dentist ____ Psychiatrist/Psychologist ____ Chiropractors ____
Massage Therapists ____ Osteopath ____ Acupuncturists ____
Other (write-in) _____

15. Do you have any of the following (Contraindications to some physical therapy treatment. Check and or write-in)

Total hip replacement ___ Pacemaker ___ No sensation _____ Other _____

16. Prior Level of Function (How long have your symptoms lasted?) _____

17. Previous treatment for this condition includes? (Check if applicable and/or write-in)

Laser therapy ___ Medication ___ Physical therapy ___

Massage therapy ___ Chiropractic ___ Acupuncture ___

Other _____

18. Write in your Pain level at best (0-10)? _____ **Pain level at worst (0-10)?** _____

19. Current functional problems posing a change due to pain or symptoms? (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 ___ walking (uneven ground) ___

20. Was the onset of this condition gradual or sudden? _____

21. Since the onset are your symptoms getting better, worse or no change? _____

22. How many times have you had similar symptoms in the past? (Check one or write-in) _____

None _____ One to five _____ More than five _____

23. Have you ever had a surgery? Y/N If yes, was the surgery related in any way to you current symptoms (Please explain)? _____

24. Nature of pain? (Check all that apply and/or write-in)

Sharp ___ Dull ___ Throbbing ___ Aching ___ Periodic ___ Occasional ___ Constant ___

Other _____

25. Has anyone in your immediate family ever been treated for the following? (Check all that apply and/or write-in)

Cancer ___ arthritis ___ Mental illness ___ High blood pressure ___ Hepatitis ___

Stroke ___ Tuberculosis ___ Emphysema ___ Anemia ___ Kidney disease ___

Chemical dependency ___ Diabetes ___ Epilepsy ___ Heart problems ___

Other _____

26. How many packs of cigarettes do you smoke a day? _____

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

28. How many alcoholic drinks do you consume per day _____ **per week?** _____

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

30. Do you have any issues with sensation (i.e. numbness, lack of hot/cold sensation, pins and needles, etc.) If so, where do you experience this? _____

31. Is there anything else missed on this questionnaire that you think needs to be mentioned?

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 your 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 denied for too many visits, **you are responsible for those charges.**

If you have any questions, please discuss them with the front office. 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: _____

INSURANCE INFORMATION

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

Circle One: Motor Vehicle/Workers' Comp. /Personal Injury

Date of injury ___/___/_____ Policy #/ Claim # _____

Insurance Company Name: _____

Claims Address: _____

City: _____ State: _____ Zip Code: _____

Adjuster/Agent Name: _____

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

Employer: _____

If your insurance has changed since you last visit please bring in your card so we may get a copy for your files.

Patient Signature: _____ Date: _____