PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		
			Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

INSURANCE ASSIGNMENT OF BENEFITS

Patient Full Name_____ ❑ Single ❑ Married

Referring Physician:_____ PH_____ FAX_____

Are You Currently Enrolled in Home Health? Yes No

CALL THE NUMBER ON THE BACK OF YOUR INSURANCE CARD AND FIND OUT WHAT YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS ARE:

POLICY #1:

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Address (if different than patient):_____

Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:_____

Employer_____ PH_____ Claim#_____

Employer address._____

POLICY #2 (if applicable)

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Declaration to Insurance Company

I hereby instruct and direct _____ insurance company to pay by check made out to the "Healthcare Provider" named below and mailed to the address below. If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the "Healthcare Provider" for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Conditions Required in Order for "Healthcare Provider" to Accept This Assignment

If any boxes are left unchecked, clinic reserves the right to refuse this assignment and patient must pay out-of-pocket for services.

- ☐ A photo copy of this assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance claims.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.
- ☐ This is a direct assignment of my rights and benefits under this policy.

DATE: _____/_____/20_____

Signature of Patient/Claimant_____

(If applicable) Signature of Policy Holder if not same as patient_____

HIPAA Notice Acknowledgement & Consent

Siskiyou Physical Therapy

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office **Siskiyou Physical Therapy** and understand my rights contained in the notice.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for **Siskiyou Physical Therapy** to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Siskiyou Physical Therapy** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Siskiyou Physical Therapy Attn: Jesse Elliott PO BOX 2630, Grants Pass, OR 97528**.

With this consent, **Siskiyou Physical Therapy** may:

- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked “Personal and Confidential.”
- Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that **Siskiyou Physical Therapy** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Siskiyou Physical Therapy** to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Siskiyou Physical Therapy** may decline to provide treatment to me.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable