WELCOME TO RESOLVE PHYSICAL THERAPY!

Thank you for choosing us to help you on your road to recovery! Please help us to serve you better, by taking a few minutes to provide the following information.

PATIENT INFORMATION

TODAY'S DATE	FIRST NAME	MIDDLE NAME	LAST NAME
MARITAL STATUS *(CIRCLE ONE)* Married Single	**DATE OF BIRTH**	**GENDER** *(CIRCLE ONE)* MALE FEMALE	**E-MAIL ADDRESS**
SOCIAL SECURITY NUMBER	**HOME PHONE NUMBER**	**CELL PHONE NUMBER**	**WORK PHONE NUMBER**
MAILING ADDRESS		**CITY/STATE**	**ZIP CODE**
PHYSICAL ADDRESS		**CITY/STATE**	**ZIP CODE**
REFERRING DOCTOR		**PRIMARY CARE PHYSICIAN**	
IF PATIENT IS MINOR, NAME OF PARENT/GUARDIAN		**PHONE NUMBER(S)**	

EMERGENCY INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY	RELATIONSHIP TO PATIENT	PHONE NUMBER(S)
ADDRESS	**CITY, STATE**	**ZIP**

RESPONSIBLE PARTY

Patients relationship to Responsible Party *(Circle one)* *SELF SPOUSE CHILD OTHER*		DATE OF BIRTH	SSN#
FIRST NAME	**LAST NAME**	**MIDDLE NAME**	**Drivers License State/#**
MAILING ADDRESS		**CITY/STATE**	**ZIP CODE**
PHYSICAL ADDRESS		**CITY/STATE**	**ZIP CODE**
HOME PHONE NUMBER	**CELL PHONE NUMBER**	**E-MAIL ADDRESS**	
EMPLOYER		**PHONE NUMBER(S)**	

HOW DID YOU FIND OUT ABOUT US? *(CIRCLE ONE)*

WEBSITE SOCIAL MEDIA FAMILY FRIEND DOCTOR OTHER:__________________

REASON FOR TREATMENT

RELATED CAUSE *(CIRCLE ONE)* *INJURY AUTO ACCIDENT FALL WORK INJURY SURGERY OTHER* _________	DATE OF INJURY/FIRST SYMPTOM:
HOW DID INJURY/SYMPTOMS OCCUR?	
WHAT AREA OF YOUR BODY ARE YOU EXPERIENCING SYMPTOMS?	

IF AN AUTO OR WORK ACCIDENT PLEASE FILL OUT BELOW:	
NAME OF EMPLOYER/THIRD PARTY	PHONE NUMBER/CONTACT PERSON
NAME & PHONE NUMBER OF INSURANCE CARRIER/COMPANY	NAME/EXTENSION NUMBER OF AGENT
CLAIM NUMBER	STATE IN WHICH INJURY OCCURRED

MEDICAL INFORMATION

MEDICAL HISTORY: PLEASE CHECK APPROPRIATE BOXES

PAST	*PRESENT*		*PAST*	*PRESENT*	
Bone			**Neurological**		
☐	☐	Osteoarthritis	☐	☐	Dizziness
☐	☐	Osteoporosis/Osteopenia	☐	☐	Fibromyalgia
☐	☐	Rheumatoid Arthritis	☐	☐	Multiple Sclerosis
Cardiovascular			☐	☐	Parkinson's
☐	☐	High Blood Pressure	☐	☐	Seizures
☐	☐	High Cholesterol	☐	☐	Stroke
☐	☐	Heart Attack	☐	☐	Traumatic Brain Injury / Concussion
☐	☐	Irregular Heart Rate	**Psychological**		
☐	☐	Pacemaker	☐	☐	Anxiety
Lung			☐	☐	Depression
☐	☐	Asthma	**Glands**		
☐	☐	COPD	☐	☐	Diabetes Type 1
☐	☐	Smoker: Packs/Day ___________	☐	☐	Diabetes Type 2
☐	☐	Sleep Apnea	☐	☐	Kidney Disease
Infection			**Other**		
☐	☐	COVID-19	☐	☐	Cancer:_________
☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	HIV/AIDS	☐	☐	
☐	☐	MRSA	☐	☐	
☐	☐	Current Infection ___________	☐	☐	

ALLERGIES: *None* *Latex* *Tape* *Other* ________________

IMPLANTED MEDICAL DEVICES? *(other than joint replacement)* YES NO

CONSENT TO TREATMENT: I give my informed consent for any provider of Resolve Physical Therapy and medically licensed or trained staff members to perform necessary treatment for me or the above listed minor child in my care.

____

Patient Signature **Date**

____

Parent/Guardian Signature **Date**

SURGICAL HISTORY	
Please list any major surgeries you have had below.	
DATE	**SURGERY**

MEDICATIONS LIST			
Please provide a copy of your current medications, dosages, frequency, and how it is administered or fill out the form below. Please let us know if any changes ever occur. We are required by insurance to have this on file.			
NAME OF MEDICATION	**DOSAGE**	**FREQUENCY**	**ADMINISTERED**
(example) Vitamin C	*1000mg*	*Once Daily*	*Tablet*

Patient Name (Please Print) **Date**

FINANCIAL POLICY

BASIC POLICY: As the patient, you are responsible for all your medical bills in our office. It is your responsibility to know your insurance contract benefits, assure collection of insurance payments to us, and negotiate disputed claims with your insurance company.

IF YOU DO NOT HAVE INSURANCE: Our policy requires payment in full today unless we have otherwise arranged a payment schedule.

IF YOU DO HAVE INSURANCE: Your co-pay or co-insurance is due at the time of service. We will bill your insurance provider electronically where available. Please present your insurance card(s) to the receptionist at the time of your appointment. Please provide a referral from your doctor if you have been given one.

WORKMAN'S COMPENSATION: If you are not compliant with your orders, your claim may be denied and you may be responsible for the entire bill. In the event that it is determined by the Worker's Compensation Board that the illness or injury is NOT a result of a compensable Worker's Compensation case, we will bill your private insurance. The balance will be your responsibility. Please provide your personal health insurance to be held on file.

MINOR PATIENTS: The parents, guardians, or adult accompanying a minor are responsible for full payment.

REJECTED CLAIMS: If your insurance company rejects your claims, or they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. Please contact us if you need to make scheduled payments.

FORMS OF PAYMENT: We accept payments in cash, check, money order, Visa, MasterCard, and Discover. We also accept post-dated checks.

DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our collection manager. If satisfactory arrangements are not made, the account will be submitted to a collection agency.

MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance.

IF YOU HAVE ANY QUESTIONS PLEASE CALL OUR OFFICE AT 541-306-1099.
By signing below you signify that you have read, understand, and agree to this financial policy.

____

Patient/Responsible Party Signature **Date**

Cancellations and No-Shows

- We require 24 hours notice in the event of a cancellation. **There is a $25 charge for a cancellation without proper notice**. This charge will NOT be covered by insurance but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- Please cooperate with us in this regard. This time hurts you because you don't receive treatment, the therapist because they had that time reserved for you, and possibly another patient who could have used that time slot.

____

Patient/Responsible Party Signature **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect. **If you would like more details on HIPAA, please don't hesitate to ask and we will provide you with more information.**

1. Uses and Disclosures we may make without written authorization.
2. Disclosures we may make unless you object.
3. Uses and disclosures with your written authorization.
4. Your rights concerning your protected health information.
5. Changes to this notice.
6. Complaints.
7. Contact Info:
   Jenny McAteer
   Ph#: 541-306-1099
   Address: 1740 NW Pence Lane, Suite 5

8. Effective Date: November 5, 2018.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed a copy of the Resolve Physical Therapy Notice of Privacy Practices or have declined to do so. I understand that Resolve Physical Therapy has the right to change its Notice of Privacy Practices from time to time and that I may contact Resolve Physical Therapy at any time to obtain a current copy of the Notice of Privacy Practices.

____

Patient Name (please print)

____

Signature of Patient, Legal Guardian, or Legal Representative

____

Relationship to Patient **Date**

Media Release Form

I herby authorize **Resolve Physical Therapy** and its agents (collectively, “**Resolve Physical Therapy**”) to use, reproduce, and publish photographs, testimonials, statements, and/or voice. I agree and understand I shall neither be compensated for the Content nor receive attribution for the Content.

I also attest that I am authorized to grant to **Resolve Physical Therapy** the right to use this Content. I understand that this Content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission.

I hereby release **Resolve Physical Therapy** from any liability of any kind related to the use, reproduction, or publication of the Content.

Print Name

Signature

Date