Southside Physical Therapy
121 NW Greenwood Ave
Suite 101 Bend, OR 97703
Phone: 541-388-2681
Fax: 541-388-9236

PATIENT REGISTRATION **DATE:**

Full name _____ Preferred Name _____
Last First MI
☐ Male ☐ Female Birth date _____ Age _____ SS#_____ Drivers Lic. ST/#_____

Address _____ Apt # _____

City_____ State_____ Zip_____

E-mail: _____

Home Phone _____ Work Phone _____ Cell Phone _____
May we contact you at the email and phone number(s) above? ☐ Yes ☐ No

Primary treatment area_____ Date of Injury/Onset of Pain (Approx.)_____
☐ Left ☐ Right ☐ Bilateral **Was this injury related to** ☐ Work accident ☐Auto Accident ☐ Chronic ☐Other: _____

How did you hear about us? ☐My Doctor ☐ Family/Friend ☐ Online Search ☐ I am a returning patient ☐ Other: _____

Referring Provider _____Primary Care Provider (If Different) _____

Other Provider(s) that you would like records sent to: _____

Employment Status ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Homemaker ☐ Student

Employer _____Occupation _____
Marital Status ☐ Single ☐ Married

Who may we contact in the event of an Emergency:

Full Name _____ Home Phone _____
Last First MI
Relation to patient ☐ Spouse ☐ Parent ☐ Other_____

May we disclose treatment/billing info to anyone (other than Ins. company and medical providers)? If so, please provide their information below

Full Name _____ Home Phone _____
Last First MI
Relation to patient ☐ Spouse ☐ Parent ☐ Other_____

INSURANCE INFORMATION *Please present your insurance card to the receptionist **AND** complete section below*

Primary Insurance Company_____ ID/Subscriber # _____ Group/Policy #_____

Name of Policy Holder: _____ Birth date _____
Last First MI

Secondary Insurance Company_____ ID/Subscriber#_____ Group/Policy#_____

Name of Policy Holder_____ Birth Date _____
Last First MI

Worker Compensation or Auto Accident Insurance Company _____

Claim # _____ Date of Injury _____

Adjuster's Name_____ Adjuster's Phone #_____

Employer _____ Employers phone #_____

Southside Physical Therapy – Pain Assessment

Date_____

Name_____ Date of Birth_____

Occupation_____ Work Type: Sedentary ___ Light Manual___ Heavy Manual_____

Age _____ Height _____ Weight _____ Primary Care Physician _____

Please List Previous Surgeries, Major Illnesses and Current Medical Conditions: _____

_____

_____

_____

Have you had any falls in the last 1 year? ____Yes ____No Were you injured in the fall? _____Yes _____No

Pain Rating – Rate your pain levels using the 0 – 10 scale below, to indicate the intensity of your pain.

Your Pain (During the last 30 days use pain scale on the right.) Pain Rating at this moment _____ Least amount of pain _____ Worst Pain: (most amount of pain) _____			**0-10 SCALE OF PAIN SEVERITY**
	Severity		Description of pain when pain is present
	0	No Pain	Pain Free.
	1	Minimal	Pain is hardly noticeable.
	2	Mild	Feel a low level of pain; aware of pain only when paying attention to it.
	3	Uncomfortable	Pain is troubling but can be ignored most of the time.
	4	Moderate	Constantly aware of the pain but can continue normal activities.
	5	Distracting	Pain is barely tolerable; some activities limited by pain.
	6	Distressing	Pain preoccupies thinking; must give up many activities due to the pain.
	7	Unmanageable	Constant pain that interferes with almost all activities; often must take time off work; nothing seems to help.
	8	Intense	Severe pain makes it hard to concentrate on anything but the pain; conversation difficult.
	9	Severe	Can concentrate on nothing but the pain; can do almost nothing; can barely talk.
	10	Immobilizing	Pain is excruciating. Unable to move except to seek immediate help for pain in emergency room. Bedridden.
		KP Northwest	

Functional Rating: List three functional activities or positions most limited by **THIS EPISODE**: (eg: sitting, sleeping, standing walking, lifting, fixing your hair, getting up from a chair, putting on shoes or pants, getting in and out of a car, turning over in bed, etc) Then score each activity limitation from 0-10. 0 = no difficulty 10 = unable to perform activity,

Activity:	**Score from 0 - 10**
1.	
2.	
3.	

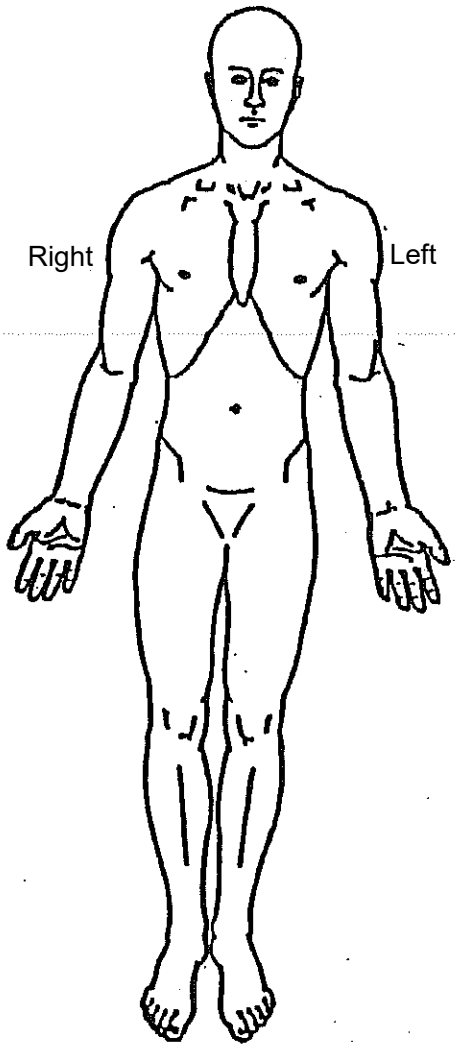
GOALS: **Please list 3 goals you would like to achieve with your treatment.**

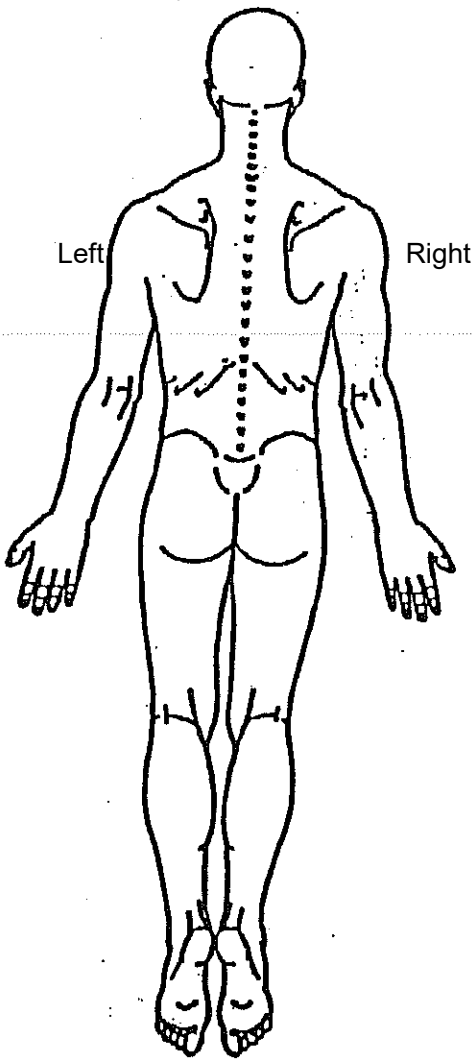
1.
2.
3.

Please complete the Symptom diagram. Thank you.

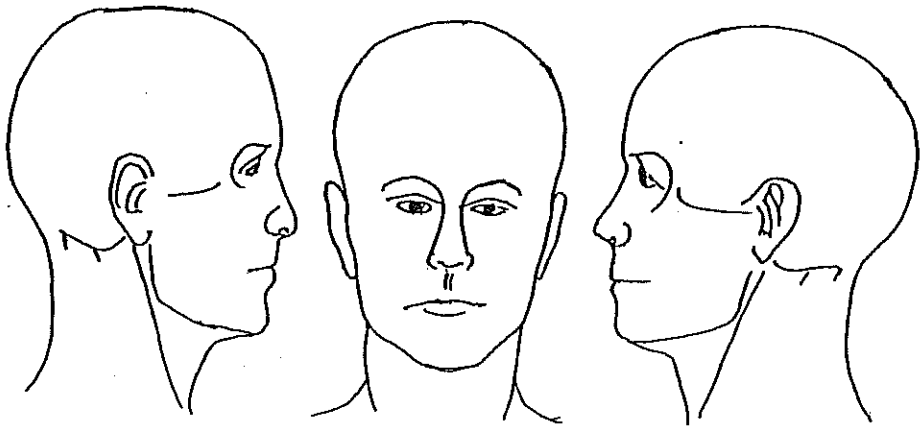
Please use the symbols below to describe your symptoms related to this current injury or condition.

/// Pain xxx Burning 000 Pins and Needles === Numbness +++ Swelling





HEADACHES & JAW PAIN



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PATIENT REGISTRATION / RESPONSIBLE PARTY AGREEMENT

*Please **read** carefully and **check** each box:*

- ☐ I consent to treatment by a physical therapist.
- ☐ I specifically authorize the release of physical therapy records and physicians' orders for therapy to the parties and insurance I have provided.
- ☐ I authorize Southside Physical Therapy, Inc. to bill my insurance company and to furnish information to them concerning my treatments.
- ☐ I assign to Southside Physical Therapy, Inc. all payments for services rendered to me or my dependents.
- ☐ I understand that I am responsible for any amount not covered by insurance.
- ☐ I understand that I am responsible for charges and fees for items and services not covered by insurance.
- ☐ Co-pays are due at the time of service.
- ☐ Patient and insurance balances are due upon receipt of the first statement and need to be paid prior to the next appointment unless other arrangements have been made.
- ☐ I understand at the end of my treatment, a representative of Southside Physical Therapy will offer either a 4-month, interest free equal payment option or an application for Care Credit as Southside Physical Therapy is a small office and cannot carry long term patient balances.
- ☐ My health insurance may also require a referral for Physical Therapy. If the referral is not presented at my first appointment, I understand my insurance may deny all charges and I will be financially responsible.
- ☐ I understand there will be a $25.00 charge for the first appointment canceled with less than 24 hour notice, and $50.00 for the second late cancellation with a possible discharge from Physical Therapy.
- ☐ I understand that there is a $25.00 charge for arriving over 15 minutes late to an appointment.
- ☐ I understand there is a $35.00 charge for non-sufficient fund checks (NSF).
- ☐ I have received or been offered a copy of this office's Notice of Privacy Practices (HIPPA NPP).
- ☐ I authorize the office to leave messages concerning treatment, appointments/scheduling and financial information via text, voice mail or email.

Sampson Physical Therapy Inc, dba Southside Physical Therapy bills your insurance as a courtesy to you. We strongly recommend that you verify your benefits with your insurance company.

I, _____ (patient or responsible party), acknowledge that **I have read** and understand the statements above and that **I am responsible for charges to my account** at Southside Physical Therapy, Inc. I promise to pay for services and supplies provided within the payment and credit policies set forth by Southside Physical Therapy, Inc. I have been informed Sampson Physical Therapy; Inc dba Southside Physical Therapy does not carry patient balances for longer than 4 months. If my account is placed in the hands of an attorney for collection or turned over to any agency for collection, I/we agree to pay all reasonable attorney fees even if no suit or action is filed thereon. Accounts assigned to a collection agency will be charged a one-time collection fee of $50 plus 9% of the outstanding principal balance at the time of assignment.

Text

Name: _____ Date: _____

Signature: _____ Witness: _____

Medication List

Please List ALL medications, Vitamins, and Supplements

Patient Name: _____ DOB: _____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

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Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Signature:_____ Date:_____

Please Note: An updated list of medications is needed at every new patient visit, even if you are returning.