Registration Form

PATIENT INFORMATION

Patient Legal Name: _____

Mailing Address: _____

Home #: _____ **Cell #:** _____ **Email:** _____

Date of birth: _____ **Gender:** ☐ M ☐ F

Occupation: _____

Emergency Contact: _____ **Phone Number:** _____

How did you hear about us? _____

INSURANCE INFORMATION / FINANCIAL RESPONSIBILITY DISCLAIMER

Policy holder NAME and DATE OF BIRTH: _____ **Phone #:** _____

Primary Insurance: _____ **Secondary**: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Turning Point Physical Therapy, LLC. I understand that I am financially responsible for any balance. I also authorize Turning Point Physical Therapy, LLC or the insurance company to release any information required to process my claims. I authorize the use of this signature on all insurance submissions. Some insurance companies limit the number of physical therapy visits in a given year. If this is the case, you must keep track of your visits so you don't exceed the parameters. If payment is denied, you are responsible for those charges. 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.

You may be assessed a 1.5% finance charge (18% annual percentage rate on balances 90 days old.

Patient/Guardian Signature: _____ **Date:** _____

DISCLOSURE AUTHORIZATION

The Physical Therapist/Staff has my permission to: (please check all boxes below that apply)

Yes	No	
☐	☐	Leave message at home with my spouse or with: _____
☐	☐	Leave a detailed message on cell phone. Cell Phone #: _____
☐	☐	Leave a detailed message on work voicemail. Work #: _____
☐	☐	Leave a detailed message on home machine. Home #:_____

Patient / Guardian Signature: _____ **Date:** _____

CANCELLATION / LATE POLICY

We request that you provide at least twenty-four hours' notice if you are unable to make your scheduled appointment. If you are calling after office hours, please leave a message with the answering service. There will be a $50.00 cancellation fee charged for failure to cancel the appointment without twenty-four hours' prior notice. This includes appointments you are more than 15 minutes late to or missed completely.

Patient / Guardian Signature: _____ **Date:** _____

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Turning Point Physical therapy to use and disclose to 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 heath care professional 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 that 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 the 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 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.

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 will be available at each appointment.

Patient / Guardian Signature: _____ **Date:** _____

OVER THE COUNTER PRODUCTS

I hereby acknowledge that at times Turning Point Physical Therapy may recommend an over the counter product. I further acknowledge that Turning Point Physical Therapy has a direct financial benefit from this purchase.

Patient / Guardian Signature: _____ **Date:** _____

"Let's change your World."

TURNING POINT
PHYSICAL THERAPY, LLC

MEDICAL HISTORY

Name: _____ **Date** ___/___/_____ **Height**: _____ **Weight**: _____

Date within the last six months of the issue or symptoms worsening: _____

Primary diagnosis: _____

Was the onset of this condition gradual or sudden? ☐ Gradual ☐ Sudden

Since the onset are your symptoms getting better, worse, or no change?
☐ Getting better ☐ Worse ☐ No change

Have you had Physical Therapy before? ☐ Yes ☐ No

Practitioners seen for this condition:
☐ Dentist ☐ Psychiatrist / Psychologist ☐ Chiropractors ☐ Massage Therapist ☐ Osteopath
☐ Other _____

Do you have any of the following (contraindications to some physical therapy treatment):
☐ Total hip replacement ☐ Pacemaker ☐ No sensation

Have you ever had surgery? ☐ Yes ☐ No
If yes, was the surgery related in any way to your current symptoms? _____

On a scale from 1-10, Pain Level at WORST: _____ **Pain Level at BEST:** _____

Nature of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Periodic ☐ Occasional ☐ Constant
☐ Pins and needles? (if so, where _____)
☐ Other _____

How did your injury occur?

☐ Trauma / accident	☐ Lifting	☐ A fall
☐ Sports Injury	☐ Overuse Trauma	☐ Work-related injury
☐ Degenerative process	☐ Other _____	☐ Unknown

What are your current symptoms? Check all that apply.

☐ Pain	☐ Mechanical pain	☐ Pins and needles	☐ Night pain
☐ Fever/chills/sweats	☐ Fainting	☐ General discomfort	☐ Difficulty breathing
☐ Bowl dysfunction	☐ Nausea/vomiting	☐ Numbness	☐ Sexual dysfunction
☐ Weakness	☐ Dysuria	☐ Dizziness	☐ Headaches
☐ Unexplained weight changes	☐ Other _____	☐ Other _____	☐ Other _____

"Let's change your World."

TURNING POINT
PHYSICAL THERAPY, LLC

Check any activity that is affect due to pain:

- ☐ Walking
- ☐ Dressing
- ☐ Carrying
- ☐ Headaches
- ☐ Standing
- ☐ Personal Care
- ☐ Reaching
- ☐ Driving
- ☐ Talking
- ☐ Squatting
- ☐ Work
- ☐ Stairs
- ☐ Reading
- ☐ Lifting
- ☐ Eating
- ☐ Sleeping
- ☐ Sitting
- ☐ Recreation/Sports
- ☐ Concentration
- ☐ Walking on uneven ground

Personal history of any of the following?

- ☐ Cancer
- ☐ Hepatitis
- ☐ Anemia
- ☐ Anorexia/bulimia
- ☐ Multiple sclerosis
- ☐ Bronchitis
- ☐ Depression
- ☐ Tuberculosis
- ☐ Chemical dependency
- ☐ Epilepsy
- ☐ HIV/Aids
- ☐ Other
- ☐ Osteoarthritis
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Thyroid problems
- ☐ Allergies
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Emphysema
- ☐ Diabetes
- ☐ Raynaud's disease
- ☐ Rheumatoid arthritis

Age of condition:

Family history of any of the following?

- ☐ Cancer
- ☐ Hepatitis
- ☐ Anemia
- ☐ Epilepsy
- ☐ Mental illness
- ☐ Tuberculosis
- ☐ Chemical dependency
- ☐ Other
- ☐ Arthritis
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Heart Problems
- ☐ High blood pressure
- ☐ Emphysema
- ☐ Diabetes
- ☐ Other

Pain Chart

Place the following symbols over the correct areas:

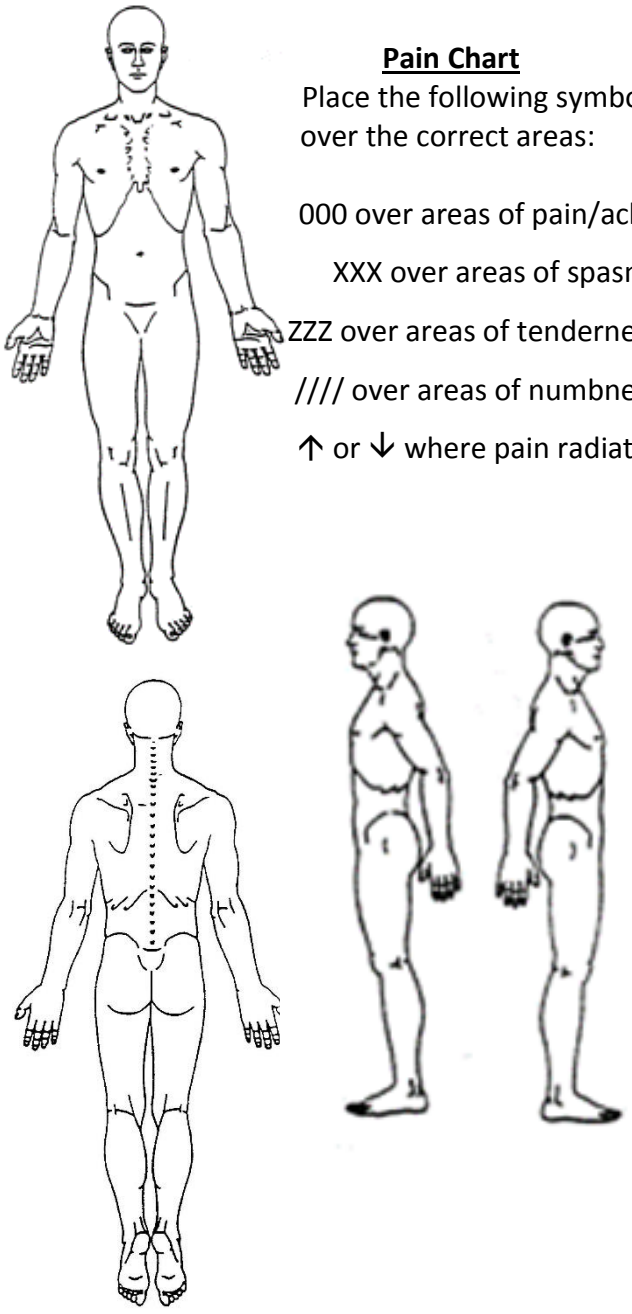
000 over areas of pain/ache

XXX over areas of spasms

ZZZ over areas of tenderness

//// over areas of numbness

↑ or ↓ where pain radiates



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

How many caffeinated (coffee, soda) drinks do you consume per day? _____

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

How many days per week do you smoke marijuana?_____

Turning Point Physical Therapy 331 S. Pacific Highway, Talent, OR 97540 Phone #: (541) 535-2551 Fax #: (541) 535-1417

MEDICATION LIST

Please list any medications that you are presently taking including all prescriptions, over-the-counter, herbal and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency, and administered route.

Medication Name	Dosage	Frequency	Administered route