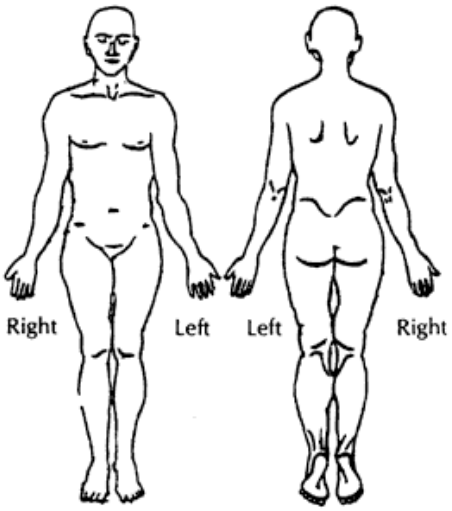
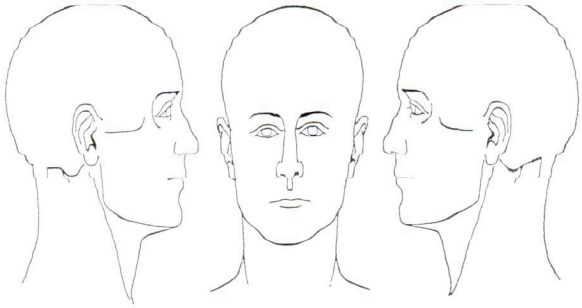
New Client Intake Forms

First name _____ Middle_____ Last_____
Birthdate____/____/_____ Your preferred name_____ Occupation _____
Home phone_____ Cell phone_____Email_____
Emergency contact_____ Phone _____ Relationship_____
Medicare insurance subscribers only: Height_____ Weight_____

I am seeking help for:_____
_____
Which is limiting me from: _____
_____
When and how did this issue begin?_____
_____
What are your goals for treatment at Shine?_____
_____

Please indicate where ALL of your symptoms are on the charts below:





Highest pain level _____ /10 Lowest pain_____ /10 Average pain _____ /10
Since onset, are symptoms getting: ___ better? ____ worse? ____ not changing?
What makes your symptom(s) worse?_____
What makes it better?_____

What other treatment have you had for this condition? Please ceck all that apply:

__Rest __Massage __Physical therapy __Acupuncture __Surgery __Medication/injection
__Ice __Heat __Orthotics __Osteopathic __Chiropractic __Brace/tape
Other:_____
Results or changes from these treatments?_____

Why do you think these treatments did or did not help?_____

Please check any of the following symptoms you have recently experienced:

__Night pain __Fatigue/weakness __Numbness/tingling __Dizziness ___Fainting
__Weight change __Fever/chills __Vision changes __Loss of bowel/bladder control

Do you currently have or have you had any of the following conditions?

*Please mark with a **C** for current to all that apply. Please mark with a **P** for past issues.*

__Diabetes __Latex allergy __High blood pressure __Diabetes __Neurological issues
__Heart issue __Stomach/GI issues __Impaired thyroid __Cancer __Metal implant/ Pacemaker
__Infectious disease (such as Hepatitis or HIV) __Asthma __Sleep apnea
Other:_____

Have you had any of the following imaging/tests? __X-ray/CT scan __MRI __other
Result(s) of these tests:_____

Physical activities at work/home: _____
How often do you exercise (beyond daily activities)?_____
How would you describe your general health?_____
Either bring a printed list to your PT visit or please list all current meds/supplements:_____
_____

List ALL past traumas, concussion, car accidents and surgeries including dates:_____
_____

Do you wear ____glasses ___contacts?

Are your glasses or contacts bifocals or progressives? ___YES ___NO

Mark any of the following that apply to you currently:

___Difficulty driving at night ___Blurry vision ___Double vision ___Eye strain

Does your jaw click or pop when you open or close your mouth? ___YES ___NO

How many headaches do you experience per week? ___0 ___1-2 ___3-5 ___5-7

Do you wear an oral appliance, retainer, or night guard? ___YES ___NO

Do you have orthotics, heel lifts or other foot inserts? ___YES ___NO

What types of shoes do you wear most often? _____

Do you experience an abnormal sense of pressure in your abdomen or pelvis? ___YES ___NO

Do you ever have any amount of urine leakage? ___YES ___NO

- If so, when? __cough __run __sneeze __laugh __lift __exercise __jump

Do you ever have an urgent and sudden sensation to urinate? ___YES ___NO

If applicable, list dates you have given birth. Please note with a **C** if they were C-sections: _____

_____

Shine Integrative Physical Therapy
Privacy and Financial Policies

FOR PATIENTS WITH HEALTH INSURANCE

We offer a complementary insurance benefits check as a courtesy. It is each patient's responsibility to understand your insurance plan(s) waiting periods, frequency limitations, deductibles, and other exceptions and exclusions. Please read the insurance benefit booklet(s) to fully understand. Should your insurance coverage change, please update us immediately.

ALL CLIENTS: You are responsible for any deductibles, co-pays, co-insurance and any services not covered by your plan. Co-pays are due at the time of service.

MEDICARE: Medicare has a financial limit of approximately $1900 per year for outpatient physical therapy. Once that amount has been met, you will be responsible for all further payments during that calendar year.

FOR PATIENTS USING OTHER TYPES OF PAYMENT

WORKERS COMPENSATION (WC): We will bill your worker's compensation carrier for your charges. In the event your claims are denied, you will become financially responsible for all treatment charges.

Motor Vehicle Accidents (MVA): In the state of Oregon, we can only use a prescription from a physician (MD, ND, DO, DPM or DMD) but not a chiropractor for MVA claims. We will bill your automobile insurance provided you have a medical claim open. In the event your claims are denied, you will become financially responsible for all treatment charges.

PERSONAL LIABILITY/LITIGATION: If you are working with an attorney for your MVA or WC claim, and are not yet to the point of settlement, our financial policy is:

- If your account balance reaches $500, we ask for 10% monthly payment.
- If your claim is partially or fully denied, you are to assume full responsibility for payments, a payment plan must be drafted within 10 business days from denial.

NON-INSURED SELF-PAY: A time-of-service discount will be applied for paying your entire invoice on the day of treatment. Discounts do not apply to supplies or equipment.

OUR BILLING PROCESS

- Claims are sent to Athena Health who submits them to your insurance company for reimbursement.
- Athena Health sends a statement to you after your insurance has processed the claim. This statement will be on your Patient Portal for optional online payment.
- Balances over 60 days will be subject to 2% monthly finance charge.
- Returned checks will be charged a $40 fee.
- Statements that are 90 days past due will be sent to collections.

I hereby authorize my insurance benefits be paid directly to Shine Integrative Physical Therapy. I understand that I am financially responsible for all services. I agree that I am fully responsible for all charges incurred here and all terms and conditions listed above.

Signature_____Date_____

Shine Integrative Physical Therapy Privacy Policy

By signing below, I agree that I have reviewed the privacy practice (in the clinic lobby and online at www.shinephysicaltherapy.com) and agree to the conditions therein.

Signature_____Date_____

Shine Integrative Physical Therapy Release of Information

In order to provide the best care possible, we may need to discuss your case with your other health care professionals. This is the best place to list your physician, specialist, massage therapist, personal trainer, etc. I hereby authorize release my medical records to the following groups or individuals:

Name:_____Contact:_____

Name:_____Contact:_____

Name:_____Contact:_____

Name:_____Contact:_____

Shine Integrative Physical Therapy Missed Appointment Policy

We are committed to helping you with your rehabilitation and expect you to attend all scheduled appointments (except illnesses or emergencies). Failure to cancel any appointment less than 24 hours prior to the start time will result in a $45 fee. Insurance will not cover this fee. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, I agree to this policy.

Signature_____Date_____

Shine Integrative Physical Therapy Patient Informed Consent

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or referring provider. I acknowledge that no guarantees have been made to me as to the results of the services at Shine Integrative Physical Therapy. It is this clinic's sincere intent to educate me on every process. If techniques that are being or plan to be used to address my symptoms are not understood fully or if I have any other questions or concerns about my care I understand that it is my sole responsibility to communicate with Shine. By signing below, I agree that I will communicate promptly and perform the prescribed activities to the best of my abilities.

Signature_____Date_____

To initiate your treatment, all sections must be signed and dated. Thank you!