Thank you for choosing PT 360° and we look forward to being part of your health care team!
We participate with most major insurance providers.

All of our appointments are one hour of one on one time with your Physical Therapist, so please arrive with your paperwork and your PT will get you started at your appointment time.

Paperwork

In order for us to learn about your history, symptom complex and personal treatment goals and to be best prepared for your initial evaluation, we are enclosing new patient forms. Please complete the forms and bring them with you at the time of your appointment, or come a few minutes early to fill them out in our office. If you have a referral from your doctor, you can have them fax it to us or bring it with you. Our fax number is 503-200-1148.

Cancellation Policy

To avoid incurring a $70 late cancellation fee, please contact us at least 24 hours (1 business day) prior to your scheduled appointment. This requirement is waived if you are ill and infectious, or if there are dangerous weather/road conditions. Please refer to the Cancellation and Missed Appointment Policy on the Conditions of Registration Form.

Billing

We offer billing services for worker's compensation, motor vehicle, Medicare claims and many private insurance companies. If your private insurance carrier is not included on our billing list, payment must be received on the day services are rendered. We accept cash, personal checks, Visa and MasterCard.

What to Wear

Please bring comfortable clothing, shorts or workout attire. Especially if we are looking at your lower back or legs.

Location

Our clinic is located at 1215 SE 8th Avenue on the corner of SE 8th and Salmon St. The building is a grayish green color, labeled "1215". There is available parking in the lot outside the building and free two-hour parking is located around the periphery of the building. If you're riding a bike, feel free to bring it into our office, there is space to park it during your appointment.

We are looking forward to becoming part of your health care team! If there is anything we can do to help, please feel free to ask.

Regards,

360° sports medicine and spine therapy staff

1215 SE 8th Ave., Suite D Portland, Oregon 97214 | Phone (503) 248-0360 | Fax (503) 200-1148
"Getting you back to the life ***you*** want to live."

Updated 6/2015

Patient Registration Form

PATIENT INFORMATION

Name ____ Social Security Number ____________________

Birthday______________________ Gender: ☐M / ☐ F ☐ Single ☐ Married ☐ Other_________________

Address ____

City/State/Zip ____

Best contact: ☐ Home________________ ☐ Cell __________________ ☐ Email ________________________________

How should we contact you for appointment reminders? ☐ Email ☐ Phone ☐ Home ☐ No Reminders

INJURY INFORMATION

Date of Injury/Onset/Surgery: __________________ Injury related to: ☐ Work ☐ Auto ☐Other___________________

Body Part(s) Injured: ____

EMPLOYER INFORMATION

Professional Title/Occupation _________________________________ Employer________________________________

Work Phone __________________________Okay to contact you at work? ☐ Y / ☐ N

Work Address____

City/State/Zip ____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name ______________________________________ Relationship to you ______________________

Emergency Contact Phone ______________________________________

PHYSICIAN INFORMATION

Referring Physician ____________________________________ Referring Physician Phone________________________

Clinic Name/Location ____

Primary Care Physician____________________________________ Phone ______________________________________

PRIMARY INSURANCE POLICY

Insurance Company ____________________________________ Phone ____

Identification/Member Number ________________________________ Group Number____________________________

Subscriber's name (if not self) _________________________________ Relation to patient ________________________

SECONDARY INSURANCE POLICY

Insurance Company ____________________________________ Phone ____

Identification/Member Number _________________________________Group Number____________________________

If Motor Vehicle Accident or Work Claim, please fill out this section:

Insurance company___________________________________ Claim Number_____________________________________

Adjuster Name ______________________________________ Adjuster's Number ________________________________

PATIENT AGREEMENT – PLEASE READ CAREFULLY

I guarantee payment of all physical therapy charges for treatment provided to the above named patient to 360° sports medicine and spine therapy. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductibles and expenses not covered by my insurance. I understand that the unpaid balance is due upon completion of care, and there is a monthly finance charge of 1.5% (18% per annum) applied to the unpaid balance after 30 days from discharge. If legal action is taken against this account, I agree to pay for all reasonable legal fees associated with this action. I agree to comply with the policies of said clinic as explained herein. **I understand that I must give 24-hour notice of cancellation if I am unable to keep a scheduled appointment.** In the event that an industrial or auto insurance exhausts or refuses to pay, I authorize 360° sports medicine and spine therapy to bill my health insurance. I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to 360° sports medicine and spine therapy and request that this assignment remain on file with my insurance carrier. I certify that a copy of this agreement shall be valid as the original.

____ _______________________________

Signature DATE Updated 6/2015

Patient Health Questionnaire – History

Name _____________________________ Weight ________ Height _________ Age________ Gender ________

Leisure activities, including exercise routine ____

____

Occupation, including activities that comprise your workday ____

____

Date of last complete physical? _______________ **Do you smoke?** ☐ No ☐ Yes, Packs/Day_____ for how long? ______

Do you use caffeine? ☐ No ☐ Yes, cups/day __________ **Do you drink alcohol?** ☐ No ☐ Yes, Drinks/week ___________

Are you latex sensitive? ☐ No ☐ Yes **Do you have a pacemaker?** ☐ No ☐ Yes

Allergies: List any medications you are allergic to ____

Have you RECENTLY noted any of the following? (Check all that apply)

□ Fevers/chills/sweats
□ Cough
□ Fainting
□ Fatigue
□ Dizziness/lightheadedness
□ Diarrhea
□ Numbness or tingling
□ Muscular weakness
□ Night pain
□ Constipation
□ Nausea/vomiting
□ Falls
□ Bowel/bladder changes
□ Difficulty maintaining balance while walking
□ Shortness of breath
□ Unexpected weight change
□ Heart burn/indigestion
□ Difficulty swallowing

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections? ☐ No ☐ Yes, describe

____

Have you EVER been diagnosed with any of the following conditions? (Check all that apply)

□ Cancer
□ Diabetes
□ Heart conditions
□ High blood pressure
□ Maladaptive pain response
□ Obesity
□ Blood Clots
□ Stroke
□ Anemia
□ Angina/chest pain
□ Hepatitis
□ Depression
□ Lung Problems
□ Tuberculosis
□ Asthma
□ Pneumonia
□ Emphysema
□ Bronchitis
□ HIV
□ Thyroid Problems
□ Osteoporosis
□ Multiple Sclerosis
□ Epilepsy
□ Liver Problems
□ Polio
□ Ulcers
□ Sexually Transmitted Disease
□ Bone or Joint infection
□ Pelvic Inflammatory Disease
□ Chemical Dependency (i.e. Alcoholism)
□ Eye problems/Infection
□ Bladder/UTI/Kidney Infection
□ Rheumatoid Arthritis
□ Other Arthritic Conditions
□ Other____________________

Has anyone in your immediate family (parents, siblings) EVER been told they have any of the following?

□ Cancer
□ Heart problems
□ High blood pressure
□ Diabetes
□ Stroke
□ Arthritis
□ Tuberculosis
□ Blood Clots
□ Thyroid Problems
□ Angina/Chest Pain
□ Depression
□ Other ____________________

For your current problem, please check professionals you have received treatment from:

□ Orthopedist
□ Neurosurgeon
□ Surgery/Surgeon
□ Physiatrist
□ Osteopath
□ Chiropractor
□ Massage Therapist
□ Acupuncturist
□ Naturopathic Physician
□ Other Physical Therapist
□ Psychologist
□ Podiatrist

How often do you feel stress is a significant factor in your life? ☐ Never ☐ Seldom ☐ Regularly ☐ Always

---

Please list any medications/supplements you are currently taking (including pills, injection and/or skin patches) or bring your list with you.

____

____

Have you ever taken steroid medication for any medical condition? ☐ No ☐ Yes

Have you ever taken blood thinning or anticoagulant medication for any medical conditions? ☐ No ☐ Yes

Surgery(s), X-rays, MRI, CAT SCAN results relating to current injury:

1.____________________________ 2._____________________________ 3.____________________________

Updated 6/2015

Patient Health Questionnaire - Symptoms

What date (roughly) did your present symptoms start? ____

What do you think caused your symptoms? ____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

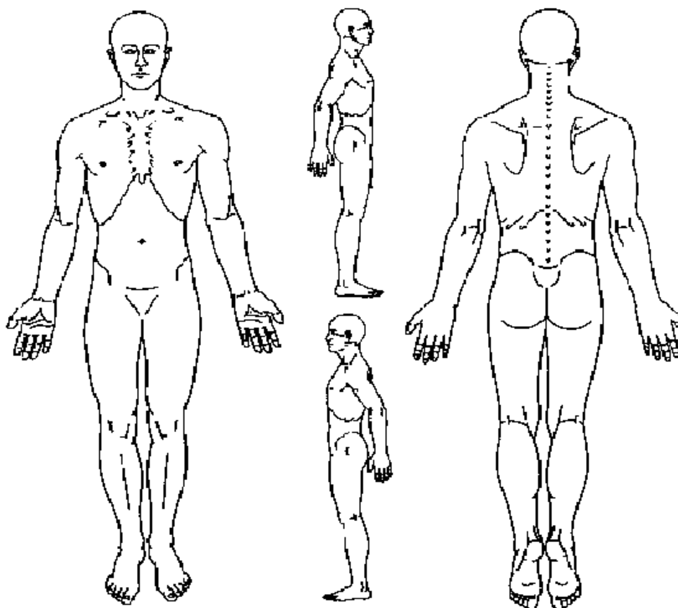
I should not do physical activities that might make my pain worse: ☐ Disagree ☐ Unsure ☐ Agree

Have you ever had this problem before? ☐ No ☐ Yes, when _______________treatment received _________________

How long did it take for you to feel better? ____

Body Chart

Please mark the chart with areas where you are feeling symptoms with the following letters to describe your symptoms:



A = Ache
P = Pins and Needles
B = Burning
S = Stabbing
N = Numbness
O = Other

My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Aggravating Positions / Activities. Identify up to 3 important positions or activities that make your symptoms worse:

1.____________________________ 2._____________________________ 3.____________________________

Relieving positions/ Activities. Identify up to 3 important positions or activities that make your symptoms better:

1.____________________________ 2._____________________________ 3.____________________________

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

When are your symptoms **best**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Exercise

Using the 0 to 10 scale with 0 being "*no pain*" and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: ___________
The **Best** your pain has been during the past 24 hours: ___________
The **Worst** your pain has been in the past 24 hours: ____________

Please describe your goals in attending physical therapy:

____

____

____

60° sports medicine and spine therapy

PROCEDURES AND FINANCIAL POLICY

OFFICE HOURS

To meet your individual needs, we offer early and late appointments. Our voice mail service will answer calls off hours and on weekends. **PLEASE CALL 911 IF THERE IS AN EMERGENCY.**

APPOINTMENTS and CANCELLATIONS

We realize unexpected situations do occur. If your schedule does change and you have to cancel your appointment, we do ask that you call in advance so that we may offer that appointment time to another patient. If you will be late, please call, as it may be necessary to reschedule your appointment time. If you miss 3 appointments without proper notice, your care may be terminated at your therapist's discretion. **WE DO CHARGE A $70 FEE, NOT COVERED BY INSURANCE, FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE OF THE PATIENT'S SCHEDULED APPOINTMENT TIME.**

PRIVACY POLICIES STATEMENT/ HIPAA

You will have an opportunity to review and question our privacy policies statement at your request. This statement will outline our policies that protect your privacy. We will release your personal health information for billing purposes to enable reimbursement for services rendered. You may request (in writing) to prevent us from doing so without penalty or cessation of your care. If you exercise this right, you will be responsible for your account balance, and you will assume responsibility for submitting billings to your insurance carrier for reimbursement.

FINANCIAL INFORMATION

COPAYS AND COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. We will try to remind you at your appointment time to make sure fees are paid. **WE WILL MAKE EVERY EFFORT TO KEEP YOU APPRISED OF YOUR PATIENT FINANCIAL RESPONSIBILITIES IN A TIMELY FASHION WITH THE UNDERSTANDING THAT THIS WILL HELP PATIENTS PLAN FOR AND MEET FINANCIAL OBLIGATIONS.** We will make every attempt to verify your benefits, however, **WE DO RECOMMEND OBTAINING INSURANCE INFORMATION YOURSELF FROM YOU INSURANCE COMPANY, AS YOU ARE THE SUBSCRIBER AND INSURANCE REPRESENTATIVES MAY PASS ON MORE DETAILED AND UPDATED INFORMATION TO THEIR OWN CUSTOMERS**. We will bill your health insurance, pip or worker's compensation directly. Any remaining balance is the responsibility of the patient.

WE DO NOT BILL SECONDARY INSURANCE UNLESS THE PRIMARY INSURANCE IS MEDICARE.

ONCE YOUR INSURANCE IS BILLED AND PAYMENTS APPLIED, WE WILL BILL YOU FOR THE REMAINING BALANCE-- BALANCES UNPAID AFTER 30 DAYS—A SECOND NOTICE WILL BE SENT OUT; FOLLOWING THE SECOND NOTICE, YOU HAVE 15 DAYS TO RESPOND/PAY. IF WE HAVE NOT RECEIVED PAYMENT WITHIN THE 15 DAY TIME FRAME, A THIRD AND FINAL NOTICE WILL BE SENT OUT; FOLLOWING THE THIRD NOTICE, YOU HAVE AN ADDITIONAL 10 DAYS TO PAY BEFORE YOUR ACCOUNT WILL BE SENT TO COLLECTIONS.

ACCOUNTS SENT TO COLLECTIONS WILL BE SUBJECT TO AN INTEREST CHARGE OF 1.5% EACH BILLING CYCLE.
CHECKS RETURNED WITH NON-SUFFICIENT FUNDS WILL BE CHARGED A $35 FEE.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO COMPLY WITH THE POLICIES SET FORTH HERE.

____ ________________

Signature Date