



REGISTRATION AND CONSENT

HLPTS INC
407 NE 12th Ave Suite 102
PORTLAND OR 97232
503-984-7198 PHONE
503-239-6125 FAX

Date _____ Date of Birth _____ Date of Injury _____

Name _____

Address _____ State/Zip _____

Cell # _____ Home # _____

Can we leave personal information on your voice mail? Yes No

Which number is best to leave a message? Home Cell

E-mail _____

Referring doctor/phone _____

Main complaint/diagnosis as you understand it _____

Goals: what you want to work on in PT _____

1. _____

2. _____

3. _____

Occupation, hours/week, physical demands: _____

Past Medical History: Date _____ Injury/Hospitalization _____

Cause of Injury _____

Medications _____

Other treatments for this complaint? _____

Check if you have had:

X-Ray MRI CT Scan Bone Scan Arthogram Physical Therapy

Check if you have had any of the following:

Allergies	Diabetes	Kidney Disease	Pregnant
Anemia	Dizziness	Multiple Sclerosis	Rheumatoid
Asthma	Emphysema/Bronchitis	Nausea	Ringing in ears
Balance or Walking Changes	Epilepsy	Numbness	Stroke
Blurred Vision	Headaches	Pacemaker	Thyroid Problem
Bowel or Bladder Changes	Heart problems	Pain with Cough/Sneeze	Tuberculosis
Cancer	Hepatitis	Pain with Deep Breath	Weakness
Chemical Dependency	High Blood Pressure	Peptic Ulcer	Other: _____

Consent for Physical Therapy Treatment:

I consent and agree to the physical therapy treatment to be provided

to: _____ by HLPTS INC as deemed necessary.

Print Patient Name

Signature of Patient/Legal Guardian (if under 18)

Date

Assignment of Insurance Benefits: I authorize all medical benefit payments to be paid directly to HLPTS INC.

I have read the above information and consent to the above terms. I acknowledge that I am the patient, or I am authorized as the patient's agent or representative to execute the above and accept the terms on behalf of the patient, or I assume individually all financial responsibility by signing this form.

Signature of Patient or person financially responsible

Date

Financial Agreement: I agree to financial responsibility for all services rendered on my behalf. I understand that payment is due at time of service, unless other arrangements have been made. I understand HLPTS INC may bill health, motor vehicle or other agency or third party payer insurance billing as a courtesy. I understand, however, this does not constitute a release of my responsibility and that I am personally responsible for all care provided to me. It is the patient's responsibility to be aware of their coverage. To avoid surprises, I recommend that you call your insurance company to confirm where your benefits stand. I agree to pay for all charges for services rendered which are not covered by insurance, including any deductible or co-pay amounts for which I am responsible.

Emergency contact:

Name: _____ Phone: _____ is able to release my whereabouts if I am not readily available and HLPTS INC and its billing agency is allowed to release financial information for the completion of amount due.

I agree to pay any applicable co-pay amount each visit. I understand that if my insurance does not make payment within 90 days, I will be responsible for paying the balance in full. Accounts billed to me are payable in full at the time of billing and I will be required to pay one and one half percent each month on any unpaid, past due balance over 30 days. If payment is subsequently made by my insurance in excess of the balance of my account, the clinic will promptly refund the credit. If it becomes necessary for the clinic to undertake efforts to collect any amounts I owe for the care provided to me by the clinic, I agree to pay for all costs and expenses of the collection actions, including reasonable attorney fees. **Canceled check fee \$50.**

Signature of patient/responsible party

Date

Appointment Cancellation:

If you need to cancel, please **call & or email at least 24hours in advance.**

Cancellations made in less than 24 hours or same day will bring a **\$50 charge.**

No shows will be charged **\$75.**

Three no shows or inadequate cancellation notices (less than 24hour notice) in 30 days may result in your discharge from therapy. All cancellations and no shows are documented in your medical records. I have read, understand and agree to all the above information.

Signature of patient/responsible party

Date

Witness

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(To be retained by medical provider)

I, _____ (print name)

Have received or been offered a copy of this office's Notice of Privacy Practices.

Signature

Date

OFFICE USE ONLY

We attempt to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment

Other _____