REGISTRATION AND CONSENT

HLPTS INC
3942 SE Hawthorne Blvd.
PORTLAND OR 97214
503-984-7198 PHONE

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 then 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_____