

601 N 1<sup>st</sup> Ave  
Stayton, OR 97383  
Phone: 503-769-3123  
Fax: 503-769-3176

602A Front St  
Silverton, OR 97381  
Phone: 503-874-4416  
Fax: 503-874-4327

## REGISTRATION FORM

### Patient Information

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ M F  
Last First MI  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: Married Single Divorce Widow Separated  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Best Phone #: (\_\_\_\_) \_\_\_\_\_ Alternative Phone #: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_  Full Time  Part-Time Phone: (\_\_\_\_) \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Primary Care Physician, (if different): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Appointment Reminder Option (please select ONE):

- Text Message: (\_\_\_\_) \_\_\_\_\_  
 Phone Call Reminder: (\_\_\_\_) \_\_\_\_\_

### INITIAL ► \_\_\_\_\_ Appointment Reminders:

Depending on which option I've selected, I give ProMotion AFR permission to contact me regarding my appointment times. ProMotion AFR will not be responsible for any additional fees/fines acquired by my carrier due to any message(s) sent. I may cancel my appointment reminder at any time in writing to ProMotion AFR. I understand that this is a courtesy feature, not a replacement of my patient responsibility.

### INITIAL ► \_\_\_\_\_ Non-Patient Minors:

ProMotion AFR understands that occasionally there will be circumstances in which my child(ren) may have to accompany me to my treatment session. This will be a **rare exception**. I understand that it is not the role, responsibility or profession of any ProMotion AFR staff member to supervise my child(ren). Additionally, if my provider feels he/she is unable to provide proper care due to my unsupervised child(ren) or that my child(ren)s behavior disrupts another patient's care they will cancel/reschedule my appointment. If I do not abide by this policy or this issue becomes consistent, ProMotion AFR has the right to terminate my care and formally discharge me from their practice.

### Insured/Parent Information (Complete if patient is under 18 and by responsible party)

Parent/Guardian: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

### Previous Physical Therapy Treatment:

Have you had Physical Therapy Treatment in another facility this year?  YES  NO  
If "yes" where did you attend?

\_\_\_\_\_  
I've read & agree to all the above statements.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ revised 11/21/2024

## FEES AND FINANCIAL AGREEMENTS

**INITIAL** ▶ \_\_\_\_\_ **Co-Payments/Co-Insurances/Deductibles:**

I understand that co-payments, co-insurances, and deductibles are due at the time of each service. I assign to and approve direct payment to PRO-Motion Advanced Functional Rehab, LLC of insurance benefits for services provided. I understand that it is my responsibility to verify with my insurance company what my Physical Therapy benefits are, along with my financial obligation for therapy treatments. As a courtesy, we often verify insurance benefits prior to your first appointment, but it is not our responsibility to ensure they are correct and accurate.

**INITIAL** ▶ \_\_\_\_\_ **Cancel/No Show Policy:**

I understand that a **one-day notice** is required for cancellation of an appointment. If I no show/cancel less than **one day prior to my scheduled appointment** time a service charge of **\$75.00** will be charged to my account. In addition, ProMotion AFR has the right to terminate my care and formally discharge me from their practice if I advance to a total of 2 no-shows during my treatment or 1 no-show on an evaluation.

**INITIAL** ▶ \_\_\_\_\_ **Waiver for Uncovered Services:**

I understand that supplies are not generally covered by insurances and that I may request services that are not covered by my carrier. I fully understand that I am financially responsible for charges not covered by this assignment. I understand that it is my responsibility to verify with my insurance company what my Physical Therapy benefits are. An ABN (advanced beneficiary notice) form will be provided to you when your insurance benefits have been exhausted or you are requesting treatment that is not covered by your current benefits. Medicare may deny payment for that specific procedure or treatment. You will be personally responsible for full payment if Medicare denies payment. An ABN will be signed when Medicare has reached maximum benefits.

**INITIAL** ▶ \_\_\_\_\_ **Finance Charge:**

ProMotion AFR may apply a 15% finance charge to my account(s) if I am in the process of being sent to a collection agency (no payments made in over 90 days) and returned checks. To avoid being billed any finance charges I agree to make monthly payment minimum of \$50 until my balance is paid in full, and I am encouraged to contact the ProMotion billing department if I need to set up a payment plan.

I've read & agree to all the above statements.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ revised 11/21/2024

## **AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

- I authorize *PRO-Motion Advanced Functional Rehab (AFR)* to release and obtain a copy of my medical information to and from my referring doctor, my primary care physician, and to my insurance company(s) as it pertains to my current physical therapy treatment.
- The information **SENT** will be used on my behalf for informing my referring doctor and primary doctor (upon request) of my progress and notifying my insurance company(s) of my status.
- The information **RECEIVED** will be used on my behalf for continuity in care.
- If you would like us to be able to share your information with a 3<sup>rd</sup> party not listed above, you can request to sign a release of records and specify which information you would like shared.

By signing below, I authorize the release of my records. I may revoke this authorization at any time by notifying *PRO-Motion AFR* in writing, unless revoked earlier, this consent will remain in effect for the duration *PRO-Motion AFR* is legally required to retain patient records.

\_\_\_\_\_

(Signature of patient or person authorized by law) (Date)



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**(HIPAA)**

(To be retained by Medical Provider)

A copy of *PRO-Motion AFR* Privacy Practice is posted at the front desk. It is available at any time to review. If any patient requests a copy, one will be provided.

\_\_\_\_\_

Please Print Patient Name

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

## CONSENT FOR TREATMENT

Physical therapy involves the use of many different types of physical evaluation and treatment. At ProMotion AFR, LLC, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

You have the right to request an open environment with the door open during your appointment. You may also request a different therapist. You may request this at any time by communicating with any employee.

Preference of provider:     MALE         FEMALE     NO PREFERENCE

Any history of personal trauma, PTSD, or any other conditions that may affect your outcome of ability to participate in formal Physical Therapy:     NO     YES

If yes, explain: \_\_\_\_\_

I want a second person present during the Evaluation and Treatment:     NO     YES

If yes, check:                       FAMILY/FRIEND                       EMPLOYEE

**I've read & agree to all the above statements.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ revised 11/21/2024

# Medical History Intake

Name \_\_\_\_\_ Dominant Hand  Right  Left

Current Occupation/ Previous Work History: \_\_\_\_\_

- Full Time  Part Time  Light Duty  Unemployed  Retired  Student  Disabled

Are you currently being treated anywhere else for any other problems OTHER than what you're being seen for today?  NO  YES

If yes, explain: \_\_\_\_\_

Check the following medical conditions that apply to **you**:

- |  |   |
|--|---|
| <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Heart Problems            | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> Pacemaker                 | <input type="checkbox"/> Difficulty Sleeping  |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Difficulty Walking   |
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Hearing Problems     |
| <input type="checkbox"/> Local Anesthetics Allergy | <input type="checkbox"/> Breathing Problems   |
| <input type="checkbox"/> Visual Problems           | <input type="checkbox"/> Recent Weight Change |
| <input type="checkbox"/> Pregnancy                 | <input type="checkbox"/> Joint Replacement    |
| <input type="checkbox"/> Complications             | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Bladder Concerns          | <input type="checkbox"/> Arthritis            |
- History of Mental health Condition? What kind: \_\_\_\_\_
- History of Cancer? What kind: \_\_\_\_\_
- History of Surgery? What kind: \_\_\_\_\_
- History of Falls in the last 3 years? When? \_\_\_\_\_

If you are currently taking any medications, please list them on the back -or-  List Provided

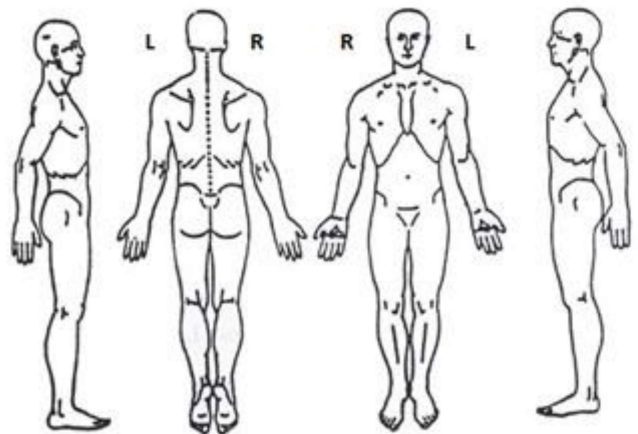
- When did the problem(s) begin? \_\_\_\_\_ month/day/year
- Description of Injury/Condition: \_\_\_\_\_
- Were you out of work at all because of your injury?  No  Yes; How Long? \_\_\_\_\_

Draw on the body diagram below exactly where your symptoms (and pain) is located:

**Based on this scale:**

- 0-No pain
- 1-Very weak
- 2-Weak
- 3-Moderate
- 4-Somewhat strong
- 5-Strong
- 6-
- 7-Very strong
- 8-
- 9-Very, very strong
- 10-Emergency (911)

<p><b>Please rate your pain</b></p> <p>NOW: _____</p> <p>Last 30 days: _____</p>
--



*\*I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form*

**Medications**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

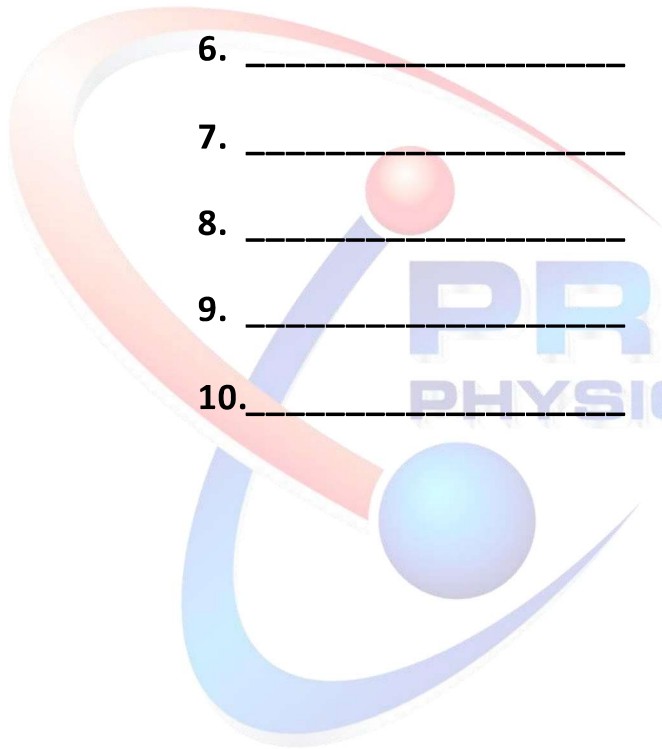
6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_



LIFE,  
LIBERTY AND  
THE PURSUIT OF  
**PROMOTION**  
PHYSICAL THERAPY

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Motor Vehicle Accident (MVA) and/or Work-Related Accident (W/C) Insurance Information**

Date of accident: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Place of accident:  Work  Car  Other (specify): \_\_\_\_\_

If work related, who was your employer at the time of accident: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Is an Attorney involved with this claim?  YES  NO

Attorney Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**INITIAL** ▶ \_\_\_\_\_ **Worker’s Compensation & Motor Vehicle Accident:**

I understand that it is my responsibility to verify with my insurance company what my Physical Therapy benefits are, along with my financial obligation for therapy treatments. ProMotion AFR has my **permission to collect private health insurance policy(s)** and bill my private insurance company if worker’s compensation/motor vehicle insurance does not cover treatment.

**INITIAL** ▶ \_\_\_\_\_ **Liens.**

I understand that ProMotion Physical Therapy does not accept liens.

**INITIAL** ▶ \_\_\_\_\_ **Authorization/Coverage Denial:**

I give ProMotion Physical Therapy permission to appeal any denials from my active insurance company.

**INITIAL** ▶ \_\_\_\_\_ **Exhausted Benefits:**

I understand that in the event that my 3<sup>rd</sup> Party insurance benefits are exhausted, I have the right to continue care at ProMotion Physical Therapy with private insurance or cash-pay rates. At that time, I will be prompted to transition my payment option(s) and sign the cash-pay insurance form as needed. In Addition, I understand that payment then becomes my responsibility if private insurance will not retro pay.

**Private/Personal Insurance Information**  Card provided/photo copy attached of your private insurance company

**Insured/Parent Information (Complete ONLY if you are not the policy holder, or if patient is under 18)**

**I’ve read & agree to all the above statements.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

revised 11/21/2024