601 N 1st 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 3rd 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**:

□ Fibromyalgia
□ Diabetes
□ Osteoporosis
□ Heart Problems
□ Pacemaker
□ High Blood Pressure
□ Circulatory Problems
□ Allergies
□ Local Anesthetics Allergy
□ Visual Problems
□ Pregnancy
□ Complications
□ Bladder Concerns
□ Hernia
□ Headaches
□ Seizures
□ Dizziness
□ Difficulty Sleeping
□ Difficulty Urinating
□ Difficulty Walking
□ Hearing Problems
□ Breathing Problems
□ Recent Weight Change
□ Joint Replacement
□ Nausea
□ 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

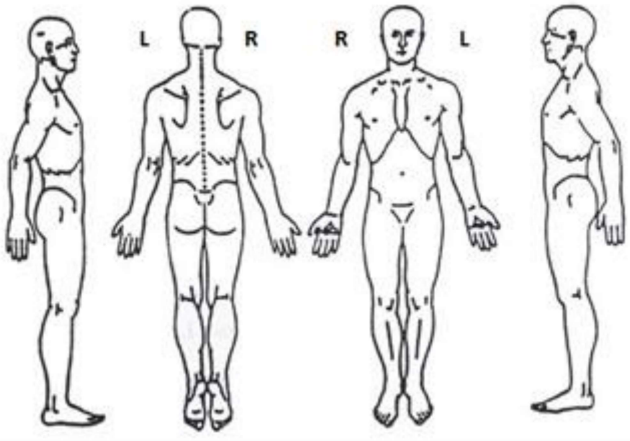
- When did the problem(s) begin? _____ month/day/year
- Description of Injury/Condition:
  _____
- Were you out of work at all because of your injury? □ No □ Yes; How Long? _____

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)

Please rate your pain
NOW: _____

Last 30 days:_____



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. _____

Patient Signature _____ Date _____