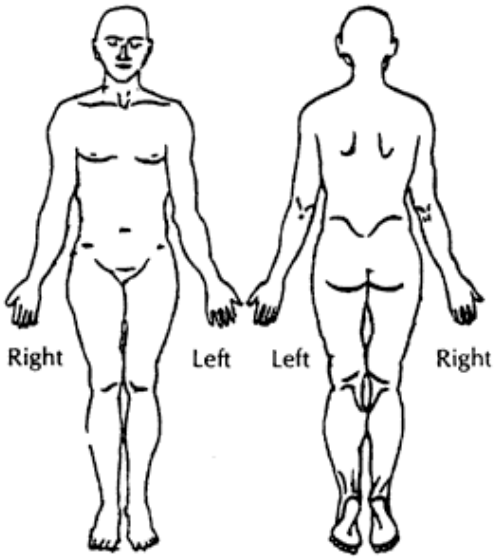
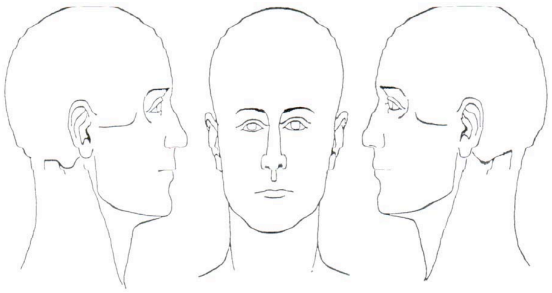
Shine Integrative Physical Therapy's Intake Form

First name _____ Middle_____Last_____
DOB_____/_____/_____ Email address_____
Address_____ City _____ State _____ Zip_____
Home phone_____Cell phone_____
Occupation _____Employer _____
Work phone_____ Emergency contact_____
Phone _____ Relationship_____
How did you hear about us?_____
Referring physician_____ Primary physician_____

I am seeking help for:_____
_____
Which is limiting me from: _____
_____
When and how did this issue begin?_____
_____
What makes it worse?_____
_____
What makes it better?_____
_____
Please indicate where ALL of your symptoms are on the body charts below:





Since the beginning of your symptoms, have you had? (please circle all that apply):
Fatigue/weakness Numbness/tingling Night pain Weight change Fever/chills
Loss of bowel or bladder control Dizziness/fainting Ringing ears Blurred vision

Highest pain _____ /10 Lowest pain_____ /10 Average pain _____ /10

Since onset, are symptoms getting: _____ better_____ worse _____ staying the same?
How/why?_____
As the day progresses, do the symptoms: _____increase _____decrease _____not change
Have you had similar symptoms in the past? ___yes ___no When?_____

Have you had any of the following imaging/tests? X-ray/CT scan MRI EMG/NCV
Results of these tests:_____

What other treatment have you had for this condition? (please circle all that apply):
Medication Physical therapy Massage Acupuncture Rest
Surgery Brace/immobilization joint work: osteopathic or chiropractic
Hypnosis Shoe inserts/Orthotics Dental/orthodontic procedure Injection
Other:_____
Results or changes from these treatments?_____
Why do you think these treatments did or did not help?_____
_____

Does the pain wake you at night? __ no __ yes: __ if lying still__ if changing positions
What position(s) do you sleep in? ___ back ___ stomach ___ right side ___ left side

Physical activities at work/home: _____
How would you describe your general health?_____
How often do you exercise (beyond daily activities)?_____
How would you describe your average stress level?_____
List ALL medications and supplements:_____
_____

Please list ALL past traumas, surgeries/operations and when they occurred:_____
_____
_____

Please list any significant family medical history:_____
_____

Have you ever had any of the following conditions? (please circle all that apply):
Vision impaired Hearing impaired Dizziness Head injury/concussion
Latex allergy High blood pressure Diabetes Stomach/GI issues
Metal implant Pacemaker Abuse Arthritis (type)_____
Thyroid impaired Blood/heart Infectious disease (Hep/HIV) Cancer
Neurological issue (epilepsy/seizure, MS, Parkinson's) Asthma/breathing disorder
Other_____

What are your goals here at Shine?_____
_____

Any other concerns or comments? _____
_____

Shine Integrative Physical Therapy's Financial Policy

We at Shine Integrative Physical Therapy strongly believe that all patients deserve the very best care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this information to acquaint you with our financial and insurance policies. Our services are provided to you and not your insurance company. Thus, payment for your treatment is ultimately your responsibility.

If you have questions about your invoice or other billing concerns, first please contact our billing company BMS at 1-800-478-2778. If questions remain please contact Shine PT's billing specialist at 503-708-7884.

FOR PATIENTS WITH HEALTH INSURANCE

Please refer to our website www.shinephysicaltherapy.com for the most updated list of our current insurance contracts. We will bill your insurance regardless of our status as in or out-of-network provider. As a courtesy to you, we will contact your insurance company and inform you of these physical therapy benefits prior to your first visit. You are required to sign the agreement with the benefits quoted prior to being seen for physical therapy. You are required to leave a major credit card on file for the entire duration of your treatment. It will be locked securely and only used by SIPT staff if 1) you incur the no-show fee or 2) you prefer the convenience of paying your bills without coming to the clinic. Please read your insurance benefit booklet(s) to fully understand all waiting periods, frequency limitations, deductibles and other exceptions/exclusions. If you change insurances, please inform us immediately.

ALL CLIENTS: You will be responsible for any deductibles, co-pays, co-insurance and any services not covered by your plan. Copays are due at the time of service. Contact our billing company BMS if you need to start a payment plan.

MEDICARE: We require a prescription for physical therapy from your *medical* doctor. As prescriptions expire in 30 days, please schedule your first visit within that time frame. Medicare has a financial "cap" of $1780 per calendar year for outpatient physical therapy & speech therapy. Once that amount has been met, you will be responsible for all further payments.

OUT-OF-NETWORK OR NON-CONTRACTED INSURANCES: You are responsible for all amounts not paid by your plan.

FOR PATIENTS USING OTHER TYPES OF PAYMENT

WORKERS COMPENSATION: If you are injured while working, we must bill your workers compensation carrier for your charges. In the event your claims are denied, **you will become financially responsible for all treatment charges**. In the event that

you seek legal representation in the settlement of your claim, you will be subject to the "Personal Liability/Litigation" policy below.

Motor Vehicle Accident (MVA): In the state of Oregon, we can only use a prescription from a MD, ND, DO or DMD (but not a DC) for MVA claims. We will bill your automobile insurance provided you have auto med-pay coverage with your policy. If that benefit is not available, we will submit your claims to your private health insurance (see above). In the event that you seek legal representation in the settlement of your claim, then you will be subject to the "Personal Liability/Litigation" policy listed below.

PERSONAL LIABILITY/LITIGATION: If you are working with an attorney for your claim, and are not yet to the point of settlement, our financial policy is:

- If your account balance reaches $500, as a courtesy we ask for 10% payment monthly, or $50 a month.
- If the balance of your account reaches $1000, we will ask that you continue to pay 10% of the balance, or $100 a month.
- If your balance reaches $1500, you will be seen on a pay-as-you-go basis.
- If your claim is denied, you are to assume full responsibility for payments, at which point, a payment plan must be drafted within 10 business days from known denial (to either you, your attorneys, or SIPT)

SELF-PAY: A discount is applied for payment of entire bill on same day of service.

OUR BILLING PROCESS

The following is intended to help you better understand our typical billing process:

- Charges are sent by your therapist to our billing service BMS who submits these charges to your insurance company.
- SIPT generally receives payment within 30-60 days.
- BMS will submit a statement to you after your insurance has paid or made a decision on services rendered (usually within 30-60 days).
- For payment, we accept cash, check, MasterCard, Visa, and Discover.
- Any balances over 60 days will be subject to 2% monthly finance charge.
- Returned checks will be charged a $20 fee.
- Statements that are 90 days past due will be sent to collections.

I hereby authorize my insurance benefits be paid directly to Shine Integrative Physical Therapy, LLC and understand that I am financially responsible for all non-covered services. I understand that if Shine Integrative Physical Therapy, LLC does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize Shine Integrative Physical Therapy, LLC to release any information necessary in order to process this claim. I agree that I am fully responsible for all charges incurred at Shine Integrative Physical Therapy, LLC and all terms and conditions listed above.

Signature_____**Date**_____

Shine Integrative Physical Therapy's Privacy Policy

ACKNOWLEDGEMENT OF HEALTH INFORMATION PRIVACY ACT THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU CAN ACCESS THIS INFORMATION

Each time you visit a healthcare provider a record of your visit (containing your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatments) is made. This Information is often referred to as your health or medical records and serves as a: basis of planning your care and treatment· Means of communication among the health professionals participating in your care · Legal document describing the care you received· Means by which you or a third-party payer can certify that the services billed were actually provided· A source of Information for public health officials· An outcomes tool to improve the care we deliver. Understanding what is in your record and how your health information is used helps you to ensure its accuracy; make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where, and why others may access your health information.

Understanding Your Health Information Rights Although your' health record is the physical property of the healthcare provider. The information belongs to you. You have the right to: 1) Request a restriction on certain uses and disclosures of your information 45CFR164.522. 2) Obtain a paper copy of the notice of Information practices upon request· Inspect and obtain a copy of your health record (45 CFR 164.524)· Request to amend your health record (45 CFR 164.528)· Obtain an accounting of disclosures of your health information (45 CFR 164.528) · Request communications of your health Information by alternative means or at alternative locations. 3) Revoke your authorization to use or disclose health Information except to the extent that action has already been taken.

We are required to: 1) Maintain privacy of your health Information and abide by the terms of this notice· Provide you with a notice as to our legal duties & privacy practices with respect to your information. Notify you if unable to fulfill a requested restriction on disclosure or amendment to record. 2) Accommodate reasonable requests you may have to communicate health information by alternative means or locations.We reserve the right to change our practices and to make the changes effective for all protected health Information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment. If you have questions and would like additional information, you may contact our clinic. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. We will not retaliate if you file a complaint.

I understand that the Shine Integrative Physical Therapy LLC will use and disclose health information about me in the course of providing care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and my include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. By signing below, I agree that I have reviewed this privacy practice and agree to these conditions. I may request a copy of this form at any time.

Signature_____**Date**_____

Shine Integrative Physical Therapy's Release of Information List

In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. I authorize Shine to release my medical records to my physician and other health care professionals and to request pertinent medical records from these professionals. **List any pertinent health care professional(s) that you authorize us to communicate with regarding your care:**

Name:_____Contact:_____
Name:_____Contact:_____
Name:_____Contact:_____
Name:_____Contact:_____

____Shine Yoga teaching staff ____Shine acupuncturist ____Shine massage therapist

Signature_____**Date**_____

Shine Integrative Physical Therapy's Missed Appointment Policy

We are committed to assisting you with your health concerns and we expect you to attend all scheduled appointments (emergency situations not withstanding). As a courtesy, you will receive a reminder email 1 day prior to your appointment. If you need to reschedule your appointment, we require 24-hour notice. **Failure to cancel your appointment within 24 hours will result in a $45 fee. Insurance will not cover this fee.** This fee will be due prior to your next appointment in order to obtain treatment. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy in its entirety.

Signature_____**Date**_____

Shine Integrative Physical Therapy's Patient Informed Consent

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the services at Shine Integrative Physical Therapy. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, IF techniques and/or exercises that are being or plan to be used to reduce my symptoms are not understood fully by me OR if I have any other questions or concerns about my care I understand that it is my responsibility to communicate with Shine immediately. I have the right to obtain a clearer understanding of what the therapist's objectives are, and how he/she is trying to achieve them. I understand that all of the therapists at Shine Integrative Physical Therapy are available weekdays by email and phone. I understand and appreciate that my rehabilitation requires a team-approach and I will honor this by communicating efficiently and performing the prescribed activities to the best of my abilities.

Signature_____**Date**_____