PATIENT INTAKE FORM

Legal Name: _____ Date:_____

Date of Birth: _____ Social Security No._____

Street Address:_____

City:_____State:_____Zip:_____

Mailing Address if Different:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Marital Status: M S D W Sex: M / F

Employer:_____Current Status: Full time / Part Time / Off work

How did you hear about us? (Please specify) Ad: ___ Foot traffic:____ Brochure:____

Website: _____ Friend/Jen Davis DPT Patient: _____ Other:_____

Date of on-set or Injury:_____Date of Surgery:_____

Referring Physician:_____Primary Care Physician:_____

Emergency contact:_____Phone:_____

Insurance: Private Ins?_____Auto?_____What State?_____On the job?_____

Insurance Carrier:_____

Claim Number (Auto or Workers' Compensation)_____

Or Patient's Soc. Sec. No.:_____

Insurance Address:_____

If Private or Auto Ins., name of insured:_____

If On the Job, employer at time of injury:_____

Secondary Insurance:_____I.D.#_____Grp#_____

If patient is a minor (under 18)

Parent/legal guardian Name: _____Phone:_____

Address:_____

Date of Birth:_____Employer:_____Phone:_____

Office, Consent and Financial Policies

Thank you for choosing Oregon Running Clinic for your specialized health care. We appreciate the confidence you have shown in choosing us to provide for your health care needs. To serve our patients in the best possible way and ensure clear communication and expectations, we have developed certain policies that are required of all patients.

OFFICE POLICIES

No Show, Rescheduled, Cancelled, or Late Appointments: We have reserved professional time and resources for your scheduled appointment time, and require that if you need to **cancel or reschedule** you provide us **48 hours advance notice from your appointment time (excludes weekends)**.

- If you miss your appointment, reschedule, or cancel with less than 48 hours-notice, we will **charge your account $75.00**.
- If you are more than 15 minutes late to your appointment, we may not be able to see you for the original allotted time, or we may need to reschedule your appointment and will charge your account **$75.00**.
- You may opt to convert your in-clinic appointment to a tele-health appointment at the same previously scheduled date and time to avoid the cancellation or reschedule fee. This is not applicable to no-shows, or late appointments.

Telephone: We are available by phone to answer your questions regarding scheduling, insurance, and general plan of care questions. Please call our office at 503-482-7234.

Email: Please know that email is only intended for scheduling updates, non-emergent and brief questions, or to clarify your treatment plan. We will typically respond within 1-2 business days.

Text: Text messaging is not allowed for two way communication due to record keeping requirements under federal and state law. The only text messages you will receive from us are for appointment reminders, satisfaction surveys, reviews, and occasionally to check in with you after your plan of care has ended.

Electronic Medical Records (EMR): The EMR system is the preferred avenue for filling out your initial paperwork, sending notices/checkups, and scheduling appointments. The systems are both designed with security in mind and are HIPAA compliant. Please be aware, though, that no system is 100% secure.

Active/Discharged: Patients are considered active if they have been seen at least once within the past 30 days. If no visit has occurred within 30 days the patient will be discharged per state law. A new evaluation will be required under state law to re-initiate continuing treatment for a prior condition, or to initiate treatment on a new condition. This includes any insurance authorization requirements.

Emergency Care: We do not provide emergency medical care, after-hours care, or treatment. We are not on-call and are not accessible after business hours. **If you are concerned that you may be experiencing a medical emergency, please call 911**. If you are not experiencing a medical emergency, you may leave a voice message on our office phone, or email us and we will get back to you with in one business day.

Patient Provider Relationship: Oregon Running Clinic reserves the right to terminate the patient provider relationship for any reason at any time.

Right to Refuse Treatment: Oregon Running Clinic reserves the right to refuse treatment to any patient for any reason at any time.

CONSENT AND FINANCIAL POLICIES

CONSENT TO TREATMENT:

I hereby acknowledge and agree that if appropriate to my diagnosis or condition:

- I consent to the appropriate use of standard physical therapy treatment services.
- I understand that I may refuse such treatment at any time.
- I understand and agree that for therapy to be effective, I must keep my scheduled appointments unless unexpected circumstances prevent me from doing so. In such an event, I agree to contact the clinic as soon as possible to discuss modifying my plan of care.
- I agree to actively participate in my physical therapy and complete my home exercise program assigned to me. If I have difficulty with any part of my treatment plan, I agree to discuss it with my therapist.

IF THE PATIENT IS A MINOR OR LEGALLY INCOMPETENT TO CONSENT TO MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN ON THEIR BEHALF AND WILL ASSUME FINANCIAL RESPONSIBILITY.

If You Have Insurance: Verification of Benefits does not guarantee reimbursement of services.
In-Network - As a courtesy, we submit claims on your behalf to your primary and secondary carriers for which we are in network with. However, you are ultimately responsible for payment. Deductible amounts, co-payments, including co-insurance payments, and payment for services not covered by your insurance are due at the time of service.

Out of Network - If you have insurance with a provider we are out of network with, you can use a third party biller Reimbursify to submit and file your claim for any out of network benefit you may have. Go to www.reimbursify.com for more information, or to file a claim. Payment for services are due at time of service.

Please advise us if you will be submitting an out of network claim, so that an itemized receipt can be prepared with the required information you will need to submit a claim.

Your insurance may require authorization for treatment. Call the number on the back of your insurance card for member services to obtain your insurance benefit for physical therapy and authorizations. If you have questions or concerns about your coverage, please contact your insurance provider ***prior*** to services being rendered. You can also contact the clinic for assistance at 503.482.7234.

If You Do Not Have Insurance, or your insurance is out of network you can elect to go "Self-Pay":
Payment for self-pay is due at time of service.

Acceptable Forms of Payment: We accept all major credit cards, debit cards, FSA, HSA, and Apple Pay. Oregon Running Clinic uses the "Block, Inc" (formally known as Square, Inc) application to accept and process all card and mobile payments.

- I hereby authorize Oregon Running Clinic to use the "Block, Inc" iPhone or iPad application to accept any card or mobile payment at the time of service.
- I further authorize Oregon Running Clinic to store my debit/credit card on file to cover any outstanding balance on my account that may arise in the future, and authorize Oregon Running Clinic to charge such card for any outstanding balance due.
- I further agree to pay a transaction fee of 3.75% per transaction for manually entered cards, and a 2.75% transaction fee for swiped, inserted, or tapped cards including e-pay applications (i.e. Apply Pay).
- I further consent to receive an email receipt of the payment made.

Past Due Accounts: Accounts that go unpaid for over 90 days or more may be submitted to a collection agency. Should the account be referred to an attorney or collection agency for collection and/or suit, the undersigned agrees to pay reasonable attorney's fees and collection expenses.

I have read and understand the Oregon Running Clinic Office, Consent, and Financial Policies. By signing this form, whether as the patient or on behalf of the patient, I accept and agree to the Oregon Running Clinic Office, Consent, and Financial Policies. I further understand and agree that my electronic signature is legally binding as my hand signature, and that I have entered into this agreement voluntarily.

Printed Name of Patient/Responsible Party: _____

Signature of Patient/Responsible Party: _____

Date Signed: _____