MOTIF
WHERE MOVEMENT AND LIFE COME TOGETHER

GEORGE FOX UNIVERSITY

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: Client Registration

Last Name	First	MI	Date of birth
Physical Address Apt#, City, State, Zip			
Mailing Address Apt#, City, State, Zip			
Preferred Phone Number	Ok to leave a message? ☐ Yes ☐ No		Sex ☐ Male ☐ Female ☐Other
Email address			
Currently Working ☐Yes ☐No	Employer		
Primary Care Physician	Referring Physician		
Emergency Contact, Relationship, Phone # ( )			

How did you find us? (Please check all that apply)

☐Doctor ☐I was a former patient ☐Family/Friend/Co-worker ☐Love INC ☐Friendview ☐George Fox

Website ☐Internet ☐ Other_____

If applicable, please provide a copy of your insurance card for our records and verification of benefits.

I _____ (name) attest that there is no ongoing legal action surrounding my condition. This includes, but is not limited to, open litigation (lawsuit), an open motor vehicle accident case, a Workers' Compensation case, or personal damages case. I attest that no legal action is connected to the condition I am seeking treatment for.

☐ *I verify that the above information is accurate.*

_____ _____
Client Signature (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: Consent for Treatment

I (please print name)_____ understand that my care as a client at George Fox University's Graduate Department of Physical Therapy is directed by supervising licensed physical therapists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care, as well as volunteer staff physical therapists, staff psychologists and staff physicians who may be associated for the purpose of consulting.

I recognize that George Fox University's Graduate Department of Physical Therapy is a teaching institution. I agree that persons who are students may participate in my care as part of the educational programs of the institution.

☐ By checking this box, I give permission for my health data to be used **anonymously** for research purposes. ***I have fully read and understand the above agreements and authorizations.***

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT

I hereby consent to the use and disclosure of my protected health information by the George Fox University's Graduate Department of Physical Therapy (GFUDPT) for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- GFUDPT has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the GFU DPT Clinic at the following mailing address:

414 N Meridian St., V 123
Newberg, OR 97132

- I understand that while GFU DPT may honor these requests, they are not required by law to do so.
- I am aware that GFUDPT reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, GFUDPT will make available a revised Notice of Privacy Practice for my review.

☐ **I acknowledge that I have been offered a copy of the GFU DPT Notice of Privacy Practices.**

_____ _____
Client Signature (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: **Patient Questionnaire**

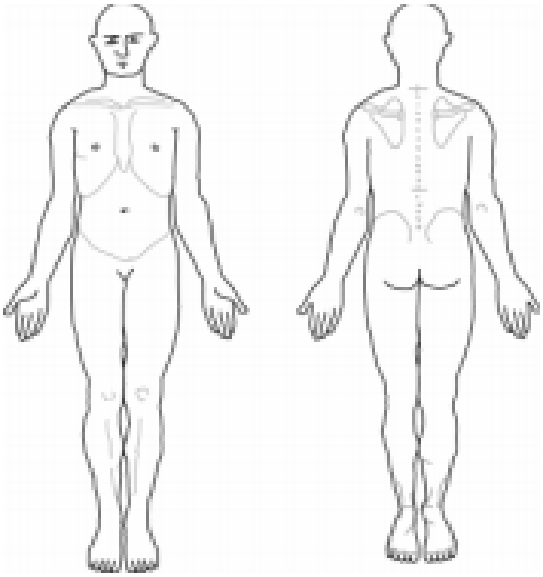
HISTORY OF PRESENT CONDITION

1. What are your current symptoms?

_____

_____.

Circle areas of **pain** or **abnormal** sensation on the body chart below:



2. When did your symptoms begin? (Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden? ☐Gradual ☐Sudden

4. How did your problem occur? (Example: a fall, a motor vehicle accident, don't know)

_____

5. Since onset, are your symptoms getting (check one): ☐Better ☐Worse ☐Not Changing

6. Nature of pain/symptoms (check all that apply):

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Occasional ☐ Constant ☐ Shooting ☐ Other_____

7. Does the pain wake you at night? ☐No ☐Yes

If yes, is it present: ☐ While lying still ☐ Only when changing positions ☐ Both

8. Please check any of the following that are NEW, UNUSUAL, or ATYPICAL for you:

☐ Regular cough
☐ Difficulty breathing
☐ Easy bruising
☐ Difficulty breathing
☐ Arm/leg swelling
☐ Heart racing in your chest
☐ Joint/muscle swelling
☐ Difficulty swallowing

☐ Fatigue
☐ Difficulty breathing
☐ Chills/sweats/fever

☐Dizzy/lightheaded
☐ Heartburn/indigestion
☐ Change in mental/cognitive abilities
☐ Constipation/diarrhea ☐Tremors
☐Blood in stool
☐ Seizures
☐Post menopause
☐ Double vision
☐ Malaise
☐ Weight gain/loss
☐ Weakness

☐ Problems urinating
☐ Loss of vision
☐ Urinary incontinence ☐ Eye redness
☐ Blood in the urine
☐ Skin rash
☐ Pregnant or might be pregnant
☐ Problems sleeping
☐ Stress at home or work
☐ Nausea/vomiting
☐ Tingling or numbness

9. Have you had any previous treatment for any of the conditions listed above? If so, please explain

_____.

MEDICATIONS

10. Which of the following have you taken in the past week:

	Physician Prescribed
☐ Aspirin	☐YES ☐NO
☐ Tylenol	☐YES ☐NO
☐ Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)	☐YES ☐NO
☐ Stomach ulcer medication	☐YES ☐NO
☐ Vitamins/mineral supplements	☐YES ☐NO
☐ Herbals/remedies	☐YES ☐NO

Please list any other physician-prescribed medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____.

Anything NOT prescribed by a physician:

_____.

GENERAL HEALTH

11. How would you rate your general health? ☐ Excellent ☐ Average ☐ Poor ☐ Good ☐ Fair

12. How often do you exercise outside of normal daily activities?

☐4-5+ days/wk ☐1-3 days/wk ☐occasionally ☐zero

13. Exercise/Sports/Recreation you do consist of:

_____

14. Do you drink caffeinated beverages? ☐No ☐Yes How many/much per day? _____

15. Do you drink alcoholic beverages? ☐No ☐Yes How many/much per day? _____

16. Do you smoke cigarettes/cigars/e-cigarettes/vape: ☐No ☐Yes How many/much per day? _____

If quit, when? _____

17. What is your current stress level? ☐Low ☐Medium ☐High

18. Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)

_____

19. Have you EVER been diagnosed as having any of the following conditions?

☐YES ☐NO Cancer. If YES, what kind: _____

☐YES ☐NO Heart Problems. If YES, what kind: _____

☐YES ☐NO High blood pressure

☐YES ☐NO Circulation problems

☐YES ☐NO Asthma

☐YES ☐NO Stomach ulcers

☐YES ☐NO Chemical dependency (alcohol or drug)

☐YES ☐NO Thyroid problems

☐YES ☐NO Epilepsy/seizures

☐YES ☐NO Diabetes

☐YES ☐NO Multiple sclerosis

☐YES ☐NO Rheumatoid arthritis

☐YES ☐NO Other arthritic conditions

☐YES ☐NO Depression

☐YES ☐NO Hepatitis

☐YES ☐NO Tuberculosis

☐YES ☐NO Stroke

☐YES ☐NO Kidney disease. If YES, what kind: _____

☐YES ☐NO Blood Clots

☐YES ☐NO Osteoporosis

Other: _____

20. Please list any recent or past surgeries related to your current problem:

_____

_____

Any other surgeries:

_____

FAMILY HISTORY

20. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐YES ☐NO Diabetes
☐YES ☐NO Cancer
☐YES ☐NO High blood pressure
☐YES ☐NO Psychological condition
☐YES ☐NO Heart Disease
☐YES ☐NO Osteoporosis
☐YES ☐NO Arthritis
☐YES ☐NO Stroke

Other_____

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: Pro Bono Qualifications

To qualify for pro bono physical therapy services you must meet one of the following criteria:

1. Meet the eligibility criteria for the 2020 Federal poverty level:

Persons in family/household	Poverty Guideline
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

2. Have no health insurance coverage due to homeless status.

3. Have been referred to the pro bono clinic by Love INC or Virginia Garcia.

You do not qualify for pro bono services if:

1. You have any health insurance other than OHP.
2. You have the means to obtain health insurance but have opted out of insurance coverage.
3. You have Medicare, private insurance, worker's compensation or have a claim that is in litigation.

I verify that I:

- I meet the federal guidelines for poverty _____ (initial)
- I do not have insurance due to homeless status _____ (initial)
- I have been referred by: Love INC _____ (initial) Virginia Garcia _____ (initial)

I further attest to the following:

- I do not have any health insurance other than OHP.
- I do not have the means to obtain health insurance.
- I do not have Medicare, private insurance, worker's compensation or have a claim that is in litigation.

Signature: _____ Print: _____ Date: _____

GEORGE FOX UNIVERSITY PHYSICAL THERAPY CLINIC: Self Pay Policy

George Fox Physical Therapy may not be a provider with your insurance plan. We offer a self-pay program for persons with these plans. We will give you an invoice to submit to your insurance company for reimbursement or to apply to your deductible.

Note: Our services may be cheaper than other providers, especially if your deductible has not been met (check with your provider). You will not be charged *more* for services than the fees listed below. The same practice may not be followed at other physical therapy clinics in the area and your fees may be greater.

Our fees:

- Initial Visit (includes your evaluation and treatment): $125
- Follow-up Visit: $75
- Student Rate: $25 each visit

Self-pay fees are due at the time of service. We accept: cash, check, debit, credit (Visa, MasterCard).

We are not able accept cash from persons with Medicare or Medicare supplement plans, those involved with a lawsuit, or persons who have an open, pending or closed worker's compensation claim.

I have read the above and verify that:

- I understand that my insurance will not be billed on my behalf. _____ (initials)
- I do not have Regence insurance or any Regence plan that covers physical therapy. _____ (initials)
- I do not have Medicare insurance, a worker's compensation claim or any claim that is in litigation. _____ (initials)
- I agree to pay in full for physical therapy services at the time of service. _____ (initials)

Signature:_____ Date:_____

Print name:_____