PORTLAND Myofascial Release

Corrie Black-Rofinot, DPT
Jamie Liptan, LMT
Rachel Wachter, DPT
Spencer Leek, LMT
Sheila Walker, PT

New Patient Intake Form

Today's Date _____

Last name: _____ **First name**: _____

Date of Birth: _____ Age: _____ Sex: F / M Gender: _____

Mail Address: _____ Pronouns: _____

City/State/Zip: _____ Phone1: _____ ☐ Home ☐ Mobile

Email Address: _____ Phone2: _____ ☐ Home ☐ Mobile

→*May we leave detailed messages at these phone numbers?* ☐ Yes ☐ No

→*Do you consent to receiving SMS messages?* ☐ Yes ☐ No

**SMS are for appointment notifications or direct communications only. You may opt out at any time by responding [STOP] or [CANCEL].*

Occupation: _____ How did you hear about us?: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

Primary Care Physician:

Name: _____

City/State: _____

Phone: _____

→*Are you covered by Medicare?* ☐ Yes ☐ No

→*Will you be submitting billing information for a motor vehicle accident claim?* ☐ Yes ☐ No

Have you received myofascial release before? ☐ Yes ☐ No If yes, from whom? _____

Primary complaint: _____

_____

History of present condition: _____

_____

Major medical history (injuries, surgeries, etc.): _____

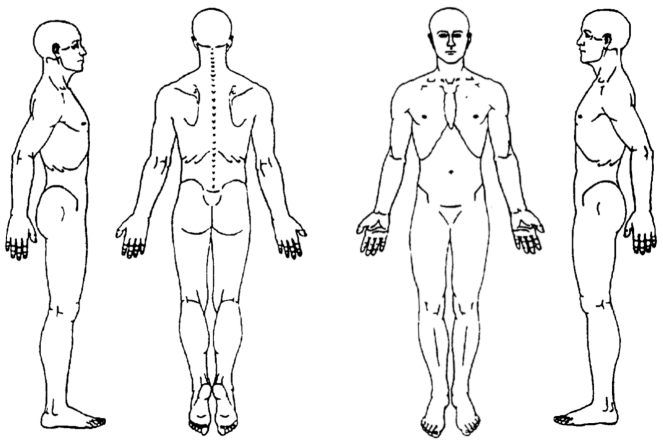
_____

Past traumas (emotional or physical): _____

_____

Using the diagram at right, please shade in areas where you usually feel pain or tension (chronic)

Please mark areas of current, particular pain or tension with an "X" (acute)



Turn over →

Prior treatments for current or similar condition: _____

Rate your average pain or symptom on a scale of 0–10 with "0" being no pain and "10" being the worst pain imaginable. Mark line at the point that represents your pain or symptom:

0_____10

Pain Description (sharp, hot, etc.): _____

What makes your symptoms worse?: _____ Better?: _____

Is your sleep disturbed because of this injury or condition? ☐ Yes ☐ No

Which activities are limited? ☐ Self care ☐ Work activities ☐ Housework ☐ Exercise ☐ Other

What over-the-counter medicines do you take (including herbs, supplements, etc.)? _____

_____

What prescription medicines do you take? _____

Have you been diagnosed with or experienced any of the following: (please check)

☐ Joint or hyper-mobility disorder
☐ Seizures
☐ Rheumatoid arthritis/osteoarthritis/tendonitis
☐ Osteoporosis
☐ Hearing loss
☐ Headaches/migraines
☐ Dizziness/balance problems
☐ Cancer
☐ Diabetes
☐ Decrease or loss of sensation
☐ Back/neck problems
☐ Fibromyalgia
☐ TMJ disorder
☐ Contagious skin condition
☐ Open sores or wounds
☐ Sprains/strains
☐ Allergies/sensitivities
☐ Heart condition
☐ High or low blood pressure
☐ Respiratory condition
☐ Circulatory disorder
☐ Bowel or bladder problems _____
☐ Pregnant? If yes, how many months? _____

Please provide any relevant details for any selected conditions: _____

_____

Treatment goals: _____

_____

Provider notes: _____

_____

_____

Please read the following and sign below:

[____] *Initial Here* I certify that the information provided herein is true and accurate to the best of my knowledge.

[____] *Initial Here* I understand that myofascial release is not a replacement for medical care and the therapist will not make a medical diagnosis. I accept responsibility for seeking medical care through a qualified health care provider. If I experience pain or discomfort, I will immediately inform the therapist so that the pressure or methods can be adjusted. As myofascial release should not be performed under certain circumstances, I agree to keep the therapist updated on any changes in my health, and I release the therapist and Portland Myofascial Release from any liability if I fail to do so.

Patient Signature _____ Date _____

Patient Representative Signature _____ Date _____

PORTLAND
Myofascial Release

CONSENT FOR TREATMENT, CONDITIONS OF SERVICE, AND FINANCIAL AGREEMENT

I hereby authorize the therapists at Portland Myofascial Release to provide physical therapy or massage therapy services approved by my referring physician, or in the case of self-referral, per Oregon law for Direct Access for physical therapists and massage therapists.

ATTENDANCE: Your success in therapy is a direct result of regular attendance to therapy, open communication with your therapist, and following your home program as prescribed. If there are issues with any of the above, we encourage you to discuss this with your therapist so modifications can be made to facilitate your success.

CANCELLATIONS / NO-SHOWS: We require **48 hours advance notice** for any change or cancellation. If you choose to reschedule or cancel an appointment within this time period you will be responsible for **50% of your appointment cost**. For changes or cancellations on the same day as your appointment or if you fail to come to your appointment without any prior notification you will be responsible for **100% of your missed appointment**. These charges will be issued as a bill and due upon receipt or payable at your next scheduled appointment. If you have a health, family, or transportation emergency please contact us as soon as you are able to so that we may attempt to fill your time. If your appointment can be rescheduled in a timely way, your therapist may decide to waive the late cancellation or no-show fee. *Patients with excessive late cancellations or no-shows will be asked to prepay for future scheduling.*

LATE ARRIVALS: If you arrive late for your appointment, you will be seen for the remaining time available and billed for the entire session. If the schedule permits, your appointment may be extended.

FINANCES: It is the intent of Portland Myofascial Release to provide quality physical therapy and massage therapy services. The following notice is provided to ensure all patients are informed of our financial policies. **Payment is due in full at the time of service**. Portland Myofascial Release is not contracted with any insurance companies, does not provide insurance billing, and is not responsible for insurance reimbursement. If you have out-of-network benefits a Superbill can be generated upon request for you to submit to your insurance company. Back-dated requests for documents will incur a **$25 documentation fee**. We accept cash, checks, or credit cards. There will be a **$25 charge** for checks returned due to non-sufficient funds (NSF).

[____] *Initial here* I have read the above **attendance policy** and understand my active participation directly relates to the success of my treatment.

[____] *Initial here* I have read the above **cancel/no-show policy** and understand I will be charged a fee for late cancellations and missed appointments.

[____] *Initial here* I have read the above **late arrival policy** and understand if arriving late I will be seen for the remaining time of the scheduled appointment and billed for the entire session.

[____] *Initial here* I have read the above **financial policy** and understand I am responsible for payment in full at the time of service.

Patient signature:_____ Date:_____

Print name: _____

Patient representative signature: _____ Date:_____

PORTLAND
Myofascial Release

Federal and state law allows us to use and disclose private healthcare information for the purposes of treatment, receiving payment, and routine healthcare operations. In order to use or disclose information about you for any other purpose we need your authorization. The Notice of Privacy Practices provided to you explains how our clinic uses and discloses information. Please read the details of the notice carefully before signing this form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received or been offered a copy of this office's Notice of Privacy Practices.

_____ _____

Patient/Representative Signature Date

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I, _____, hereby authorize Portland Myofascial Release to obtain, use and disclose any necessary health and medical information about me for the purpose of treatment, payment, or healthcare operations.

Any person listed below has my permission to discuss my health care with representatives of the practice for purposes of treatment, payment, and operations.

1. Name _____ Relationship _____
2. Name _____ Relationship _____
3. Name _____ Relationship _____

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot undo any uses or disclosures previously made with your authorization.

I have reviewed and I understand this Authorization. I also understand the the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Patient Signature _____Date _____

Patient representative signature _____Date _____