MOJO
PHYSICAL THERAPY

Legal Name _____ Today's Date _____
Last First MI

Mailing Address _____
Street City State Zip

Physical Address _____
Street City State Zip

Home phone with area code _____ Mobile phone _____

Work Phone _____

E-Mail _____ Preferred method of contact _____

Social Security Number _____ Date of Birth____/____/_____ Sex __M __F
MM / DD / YYYY

Marital Status _____

Insurance Company _____ Phone _____

Name of Insured _____ Date of Birth____/____/_____
MM / DD / YYYY

Primary Care Provider _____ Referring Provider _____

Employer _____ Employer's Address _____

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

Guarantor of Minor

Name _____ Social Security Number _____ Date of Birth _____
MM/DD/YYYY

Mailing Address if different from above _____
Street City State Zip

Home phone with area code _____ Mobile phone _____ Work Phone _____

Relationship to Patient _____

Mojo Physical Therapy LLC
2211 NW Professional Drive, Suite 204, Corvallis, OR 97330
phone: (541) 207-3720
fax: (541) 207-3729

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PHYSICAL THERAPY

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist with Mojo Physical Therapy LLC. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witnessed my signature of this consent in his presence.
The physical therapist has informed me of expected benefits and possible complications or discomfort that may result from physical therapy interventions. In addition, the physical therapist has explained to me the risks of receiving no treatment.
The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.
I have been given on opportunity to ask questions and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Patient or Guardian _____/_____ Date_____
Signature (Print Name)

Relationship, if signed by person other than patient _____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands my explanation.

Physical Therapist_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have __RECEIVED
__BEEN OFFERED BUT DECLINED
Mojo Physical Therapy Notice of Privacy Practices for protected health information.

Patient or Guardian _____ Date_____
Signature

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MOJO PHYSICAL THERAPY

MOJO PHYSICAL THERAPY LLC (MPT)
FINANCIAL POLICY

1. INSURANCE: Physical therapy services are provided directly to you, not an insurance company. As a courtesy to our patients, MPT will bill the patient's insurance company. Any balance not covered by the insurance company will be the responsibility of the patient. If problems with insurance coverage arise, it is the responsibility of the patient to communicate with the insurance company. (Initials) _____
2. AGREEMENT TO PAY: I agree to pay any balance remaining after the insurance company has been billed. If a collection agency's services are required, I further agree to pay for all legal fees and collection agency fees in connection to my debt. If the debt is not paid within 60 days of the visit, a late fee of $15 will be applied to my account. An additional $15 will be applied every 30 days until the debt is paid. (Initials)_____
3. COPAYMENTS: Co-pays must be made at the time of the visit. If the copay is a percentage of the treatment cost, an estimated payment will be collected at the time of the appointment. (Initials)_____
4. DEDUCTIBLES: If a patient has not yet met their insurance deductible, payment for the visit is due at the time of the appointment. (Initials)_____
5. SPECIAL NEEDS: Special circumstances may occur and it may be necessary to set up a payment plan. If this becomes the case, please notify us at the earliest opportunity. Payment plans must be made in writing. (Initials)_____
6. CANCELLATIONS and NO-SHOWS: Cancellations must be made at least 24 hours in advance of the appointment. Rescheduling may be done at any time. Cancellations within 24 hours or missed visits will be billed at $75 per incident. The insurance company will not pay this charge as no care was provided. Two missed visits will result in discontinuation of care from MPT. (Initials)_____

PATIENT RESPONSIBILITY

I have read and understand the financial policy of MPT. By signing this form, I consent to the above terms and conditions of treatment. I hereby authorize payment by my insurance carrier or other designated payer of medical benefits to MPT. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I also authorize APT to release to my insurance carrier or their agents any medical information needed to determine these benefits or the benefits payable for service.

Patient or Responsible Party _____/_____ Date_____
Signature (Print Name)

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MOJO
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Mojo Physical Therapy (MPT)
Authorization to Release Health Information

1. Authorization for disclosure of protected health information: I voluntarily authorize MPT to release my health information during the term of this authorization to the recipient I have designated below.
2. Recipient: Name of person or group to whom MPT may release my health information including address or other contact information as necessary

   _____
3. Purpose: The purpose of this release is
   - __ Coordination of care
   - __ Improve assessment and treatment planning
   - __ Other: _____
4. Information to be disclosed
   - __ All of my health information that MPT has in its possession
   - __ All of my health information except the following: _____
   - __ Only the following types of information: _____

5. Term: The duration of this Authorization is ninety days unless otherwise noted on this document
6. Re-disclosure: I understand that once MPT releases my health information to the recipient listed above, APT can not guarantee that the recipient will not share the information with a third party. The third party may not be required to abide by state and federal law governing the release of health information.
7. Right to Revoke: I understand that I may refuse to sign this Authorization or revoke this Authorization in writing at any time and for any reason. I understand that MPT will not condition my treatment on whether I sign or revoke this Authorization.
8. Limitations: This Authorization does not extend to STD/HIV test results, mental health notes, or drug and alcohol treatment records unless specifically requested by the patient.

Patient's Signature: _____ Date:_____

PERSONAL GUARANTOR FOR MINOR
(If the Patient is a minor under 18 years of age, a Responsible Party must complete the following)

I agree to the terms and conditions of this Authorization as it applies to the minor patient in question.
Responsible Party: _____ Date: _____

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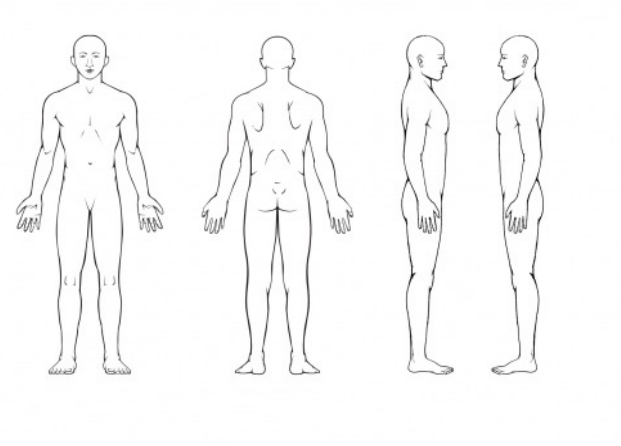
Name:_____

HISTORY OF PRESENT CONDITION
What are your symptoms? _____
_____
_____

Shade in areas of pain or abnormal sensation on the body diagrams below



When did your symptoms begin? _____

Was the onset of this episode gradual or sudden?
__ gradual __ sudden

Which of the following best describes the cause of your current symptoms?
__ car accident
__ a fall
__ trauma
__ incident at work
__ during recreation
__ Other _____
__ lifting
__ overuse
__ throwing
__ degenerative process
__ unknown

Please mark your current pain intensity
_____
None Worst imaginable

Since onset, are your symptoms getting:
__ better __ worse __ not changing

Have you had similar symptoms in the past? _____
If so, about how many episodes? _____
When was the very first episode? _____
As the day progresses, do your symptoms:
__ increase __ decrease __ stay the same

Does the pain wake you at night? __ yes__ no

Do you have pain and stiffness when getting out of bed in the morning? __ yes __ no

Since the onset of your current symptoms have you had:
__ any change in bowel or bladder function
__ fever / chills
__ numbness
__ any dizziness
__ fainting or loss of consciousness
__ weakness
__ unexplained weight change
__ night sweats
__ problems with vision or hearing
__ nausea or vomiting
__ none of the above

What makes your symptoms worse? (Check all that apply)
__ sitting
__ standing
__ walking
__ stairs
__ carrying
__ reaching back
__ coughing / sneezing
__ looking side to side
__ stress
__ working
__ lying down
__ running
__ reaching overhead
__ lifting
__ sleeping
__ looking up
__ swallowing
__ repetitive motions including_____
__ sports including_____

What improves your symptoms?
__ sitting
__ heat
__ rest
__ stretching
__ massage
__ walking
__ acupuncture
__ nothing
__ standing
__ cold
__ medication
__ brace / splint
__ exercise
__ lying down
__ joint manipulation
__ other _____

Have you had any treatment for this condition?
__ no
__ physical therapy
__ acupuncture
__ bracing / splint
__ injection
__ exercise
__ other_____
__ medication
__ massage
__ chiropractic
__ surgery
__ hospitalization
__ orthotics

Have you had any of the following tests for this condition?

__ none __ X-Ray
__ MRI __ CT scan
__ Bone scan __ labs
__ Nerve conduction __ EMG
__ other _____

Please list all prescription medications you are currently taking, including those taken "as needed" with dosages:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently taking any of the following over the counter medications?

__ Tylenol __ Ibuprofen
__ Naproxen __ Aspirin
__ vitamins / supplements
__ Other _____

Occupation_____

__ full time __ student
__ part time __ retired
__ self employed __ work at home
__ unemployed
__ other _____

Regular activities at work

__ prolonged sitting __ prolonged standing
__ repetitive lifting __ heavy lifting
__ driving __ computer use
__ other _____

Are you filing a workers' compensation claim?

__ yes __ no

Are you receiving or seeking disability benefits for this condition?

__ yes __ no

Do you exercise outside of work and normal daily activities?

__ 5+ days / week __ occasionally
__ 3-4 days / week __ none
__ 1-2 days / week

Type of exercise / recreation

_____
_____

Do you smoke

__ yes __ no Packs per day _____

Are you seeing any health care providers other than the physical therapist for this condition?

__ primary care doctor __ specialist doctor
__ acupuncturist __ massage therapist
__ chiropractor __ naturopath
__ other_____

Have you <u>ever</u> had any of the following conditions?

__ cancer __ heart problems
__ stroke __ kidney problems
__ lung problems __ high blood pressure
__ thyroid problems __ diabetes
__ arthritis __ multiple sclerosis
__ head injury __ spinal cord injury
__ Parkinson's __ osteoporosis
__ blood disorders __ seizures
__ hepatitis __ tuberculosis
__ circulation problems __ broken bone
__ depression __ anxiety
__ stomach problems __ urinary problems
__ other _____

Please list all prior surgeries with approximate dates:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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