Journey to Health PT
Dr. Angela Grenier PT, DPT, LMT
Journeytohealthpt.com

Journey to Health PHYSICAL THERAPY

8835 SW Canyon Lane #125
Portland, OR 97225
503-809-2288

RETURN THIS FORM TO BILLING OFFICE

AUTO COLLISION INFORMATION

Patient Name: _____

Date of Collision: _____ Today's Date: _____

INSURANCE INFORMATION

Name of Policy Holder: _____

Name of Policy Holder's Insurance Company: _____

Phone Number: _____

CLAIMS OFFICE

Address: _____

Claim Representative's Name: _____

Phone Number: _____ Fax: _____

Claim Number: _____ Email: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Journey to Health Physical Therapy and Wellness Clinic (J2H) to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for the service(s) provided to me. In addition, the undersigned hereby authorizes payment directly to J2H for all medical benefits otherwise payable to the undersigned or the patient.

I understand that I am responsible for all charges incurred at J2H regardless of my insurance coverage.

Patient/Guardian Signature: _____ Date: _____

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Auto Collision Questionnaire

Patient Name: _____ Today's Date: _____

Date of Collision: _____ Time of Collision: _____: _____ ☐ AM ☐ PM

Location of Collision: _____

Were you: Driver / Passenger (circle one)

Were you wearing a seat belt? ☐ Yes ☐ No
With a shoulder harness? ☐ Yes ☐ No

Your car: _____ (Year Make Model)

Other Car: _____ (Year Make Model)

☐ Front impact ☐ Side impact ☐ Rear impact ☐ Non-collision: _____

Describe what happened to your body upon impact: _____

_____

Estimated speed of **your** car: _____ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Estimated speed of **other** car: _____ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Did you brace for impact? ☐ Yes ☐ No

Was your foot on the brake: ☐ Yes ☐ No

Describe your body position at impact?
☐ head forward ☐ head turned left ☐ head turned right
☐ body forward ☐ body turned left ☐ body turned right
☐ other: _____

Did any part of your body strike the inside of the car? ☐ No ☐ Yes: _____

Any cuts, bruises or abrasions? ☐ No ☐ Yes: _____

Hit your head or lose consciousness? ☐ No ☐ Yes: _____

Were the police summoned? ☐ No ☐ Yes
Did you go to the hospital? ☐ No ☐ Yes

Was an ambulance summoned? ☐ No ☐ Yes
Were x-rays taken? ☐ No ☐ Yes

Have you been examined and/or treated for your injuries? ☐ No ☐ Yes (please describe):

_____

_____

Circle all that apply: Emergency room / X-rays / CT / MRI / Pain Medication / Muscle Relaxers / NSAIDS

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Questionnaire Continued

Patient Name: _____ Today's Date: _____

How did you feel immediately after the collision? _____

_____

Could you move all parts of your body? ☐ Yes ☐ No: _____

Could you exit the car and walk unaided? ☐ Yes ☐ No: _____

How did you feel **that night**? _____

_____

How did you feel over the **next few days**? _____

_____

Check any symptoms that have occurred since the collision:

☐ headache	☐ neck pain/stiffness	☐ mid back pain	☐ low back pain
☐ dizziness	☐ numbness (arms/hands)	☐ shortness of breath	☐ numbness (legs/feet)
☐ fatigue	☐ sleeping problems	☐ nervous/anxious	☐ tension

☐ Other: _____

Have you missed time for work? ☐ No ☐ Yes : missed full time work: from _____ to _____

missed part time work: from _____ to _____

Are your work activities restricted as a result of this injury? ☐ No ☐ Yes: _____

_____

Did you have any physical complaints just before the collision? ☐ No ☐ Yes: _____

_____

Check any symptoms that you had ***BEFORE*** the collision:

☐ headache	☐ neck pain/stiffness	☐ mid back pain	☐ low back pain
☐ dizziness	☐ numbness (arms/hands)	☐ shortness of breath	☐ numbness (legs/feet)
☐ fatigue	☐ sleeping problems	☐ nervous/anxious	☐ tension

☐ Other: _____

_____

Patient/Guardian Signature: _____ Date: _____

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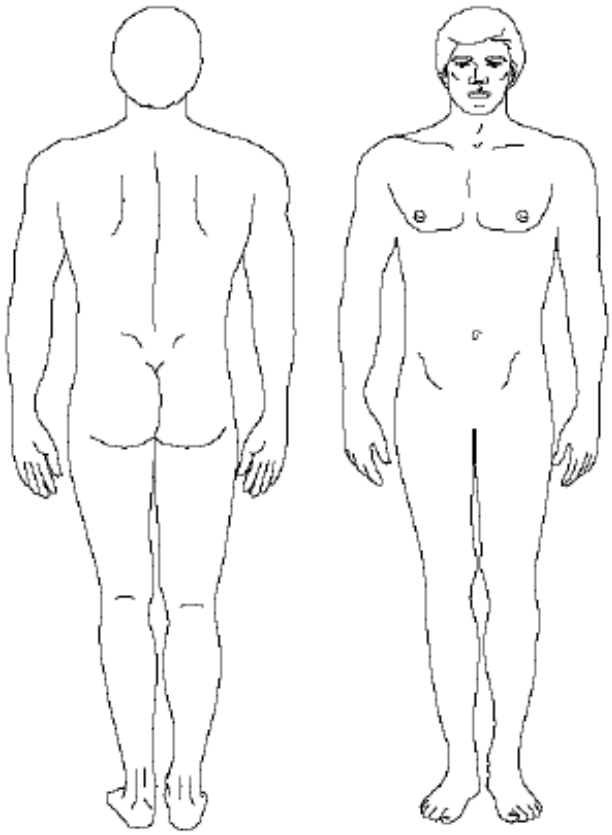
Patient Initial Intake

Patient Name: _____ DOB: _____ Date: _____

Describe your symptoms: _____
_____
_____
_____

Indicate the location of your symptoms:



Describe any activities affected by your symptoms:
_____
_____

When did your symptoms begin? _____
_____

Are you symptoms getting worse? ☐ No ☐ Yes
Does it keep you from working? ☐ No ☐ Yes
Does it keep you from sleeping? ☐ No ☐ Yes

Have you seen a chiropractor before? ☐ No ☐ Yes
Are you under the care of a physician? ☐ No ☐ Yes
Name of physician: _____

Please list current medications and reasons for taking them:
_____
_____

Have you ever experienced:	No	Yes	If yes, briefly explain:
☐ broken bone	☐	☐	_____
☐ hospitalization/surgery	☐	☐	_____
☐ strains/sprains	☐	☐	_____
☐ fallen/struck unconscious	☐	☐	_____
☐ auto collision/work injury	☐	☐	_____

Please list any other health conditions (10 years): _____
_____
_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/day _____
☐ Heavy	☐ Heavy Labor	☐ Stress level	Reason _____

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Review of Systems

Patient Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if physical therapy treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C	P	Muscle / Joint
☐	☐	Neck pain, stiffness
☐	☐	Pain b/t shoulders
☐	☐	Low back pain
☐	☐	Sciatica
☐	☐	Painful tailbone
☐	☐	Poor posture
☐	☐	Spinal curvature
☐	☐	Foot trouble
☐	☐	Swollen joints
☐	☐	Bursitis

C	P	Pain
☐	☐	Headache
☐	☐	Eye
☐	☐	Ear
☐	☐	Abdomen
☐	☐	Chest
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Elbows
☐	☐	Forearm
☐	☐	Hand
☐	☐	Hips
☐	☐	Thigh
☐	☐	Knee
☐	☐	Shin
☐	☐	Ankle
☐	☐	Feet

C	P	Numbness
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Forearm
☐	☐	Thigh
☐	☐	Shin / calf
☐	☐	Feet

C	P	General
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Concussion
☐	☐	Allergy
☐	☐	Skin rash
☐	☐	Enlarged glands

C	P	Cardiovascular
☐	☐	Hardened arteries
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heartbeat
☐	☐	Slow heartbeat
☐	☐	Swelling of ankles

C	P	Gastrointestinal
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Vomiting

C	P	Genitourinary
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lose bladder control
☐	☐	Kidney infection
☐	☐	Painful urination
☐	☐	Prostate trouble

C	P	WOMEN ONLY:
☐	☐	Congested breasts
☐	☐	Lumps in breast
☐	☐	Menstrual pain
☐	☐	Irregular cycle
☐	☐	Excessive flow
☐	☐	Hot flashes
☐	☐	Menopause

C	P	Respiratory
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spit up blood

Check any conditions you have presently OR have had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes **Pregnant**: ☐ No ☐ Yes ☐ Planning

Please list any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

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New Patient Registration

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security #: _____ - _____ - _____

Address: _____

Primary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

Secondary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

E-mail: _____ ☐ opt-in ☐ opt-out

Employer: _____ Occupation: _____

Primary Physician's Name: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Address: _____

Next of Kin: ☐ same as emergency ☐ other: _____

Who may we thank for referring you? _____

Payment information

☐ I will pay my balance in full at time of service
☐ I prefer to make payment arrangements prior to services being rendered
☐ I intend to bill insurance (auto collision):

Name of Insured _____ Relationship to Patient: _____

Insurance Company: _____ Claims Phone: (_____) _____ - _____

Claim #: _____ Representative name: _____

Date of collision: _____ Other contact info: _____

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY, HIPAA, & PHYSICAL THERAPY CARE CONSENT FORM

Clinic Financial Policy

Insurance Plans Billed – None.

You, the patient, are responsible for paying out-of-pocket at the time of service. Our office will provide the patient with a Super Receipt/Invoice to submit to his/her insurance plan for reimbursement. Angela Grenier, PT, DPT does not accept payment from any insurance company except for personal injury claims (auto-accident and worker's comp).

Time of Service Fee Schedule

- New and follow-up patient visit 60 minutes - $120

Missed Appointments or Late Cancellations: ***72 hour notice is appreciated, cancellation <48 hours results in a $50 charge, and 24 hours or less cancellation results in a charge of the full visit missed.***

Personal Injury Claims & Billing

- Auto accident and worker's comp related injuries require verification of an existing claim prior to examination and treatment.
- If examination and treatment for auto and work-related injuries are not covered by any or all personal injury insurance companies involved, I, the patient, am responsible for all fees for treatment.
- Payment is due at the time of service.

HIPPA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our staff, and others outside of this office that are involved in your care for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. All your information is strictly confidential. Please direct your questions to our office.

Examination & Treatment Consent

Physical therapy examination and therapeutic procedures (including joint mobilizations and manipulations, heat/ice application, therapeutic exercise, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal manipulation is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications such as stroke are estimated to be in the range of .5 – 2 incidents per million manipulations of the neck, and 1 per million for manipulations of the low back.

I have read and understand the above statements regarding treatment side-effects. I was made aware of procedures, alternative treatments, risks, and I was provided the opportunity to ask questions regarding recommended treatment(s) &/or procedure(s). I also understand that there is no guarantee or warranty for a specific cure or result.

Please read the following carefully:

- I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, pacemaker, etc.), I should discuss this with the physician because it may affect care.
- Notice to pregnant women: all females must alert their doctor if suspecting or having confirmed pregnancy as some therapies prescribed could present a risk to the pregnancy.
- I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Journey to Health PT reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with payment and/or reasonable treatment plans.

_____ _____ _____/_____/_____

Patient/Guardian PRINT NAME Signature Date

_____ _____/_____/_____

Signature (Dr. Angela Grenier, PT, DPT, LMT or relief doctor) Date