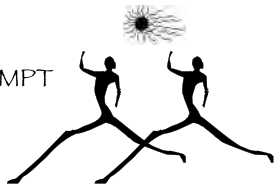
Active Life

Leslie M. Wallace MS MPT
Active Life Physical Therapy



Hello And Welcome To Active Life Physical Therapy!
We are very happy that you have chosen us for your physcial therapy needs. The following information is necessary for our records and to make your treatment with us go smoothly. Thank you in advance for reading the following pages and filling out the forms thoroughly as this will expedite your billing process.
Again, thanks for choosing Active Life Physical Therapy.

APPOINTMENT CANCELLATION POLICY

Your appointment is very important to us. Missed appointments compromise our ability to address your needs, as well as the needs of other patients waiting for appointments.

A 24 hour notice is required to reschedule or cancel your appointment (we will make allowances for illness). This is in order to allow other patients who need an appointment, a chance to schedule in these appointment times.

If we receive less than 24 hours notice, you will be charged in full for your missed appointment which will need to be paid in full prior to your next appointment.

If you need to cancel your appointment after hours or on weekends, please leave a message on our voicemail.

Thank you!

Leslie Wallace MS, MPT

1034 Lawrence St. • Eugene, OR 97401
541.284.2084 • fax 541.485.1087

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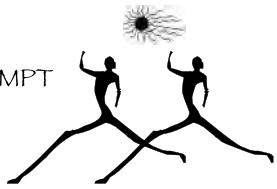

NOTICE OF PRIVACY PRACTICES

We are committed to preserving the privacy of your personal health information. Providers are required by law to protect the privacy of your medical information and to provide you with notice to inform you of:

- How medical information about you may be used and disclosed and how you can access this information.
- We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws to use and disclose your medical for other purposes without your consent or authorization.
- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think you rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES available for you to read, which fully explains your rights and our obligations under the law. We may revise our notice from time to time.
- You have the right to receive a copy of our most current notice in effect. If you have not yet read a copy of our current notice, please ask the front desk and we will provide you with a copy.

If you have any questions about this NOTICE or your medical information, please contact the office at 284-2084.
If you would like a detailed copy of our current notice, please ask the front desk and we will provide you with one.

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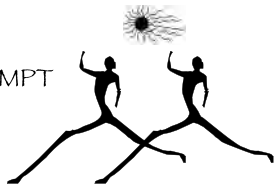

PATIENT REGISTRATION

Date:_____ Patient's Legal Name: _____ Birth Date: _____
Last First Middle Initial

Mailing Address_____ Age: _____
City:_____ State:_____ Zip:_____ Sex: ❒ Male ❒ Female
Street Address If Different:_____Marital Status: _____
Home Phone:(_____)_____ Cell /Message Phone:(_____) _____
email: _____
Employer: _____ Work Phone:(_____)_____ Occupation: _____
Family Doctor:_____ City:_____ State: _____
Spouse/Partner: _____
Employer: _____ Work Phone:(_____)_____ Occupation: _____
Emergency Contact Name: _____ Relationship: _____Phone: (_____)_____
Referring Physician (First, Last, City):_____Phone: (_____) _____
Responsible Party (If Minor): _____
Employer:_____ Work Phone:(_____)_____ Occupation: _____
Nearest Relative (Not Living With You) / Relationship To Patient:_____ Phone: (_____) _____

Is This An On The Job Injury? ❒ Yes ❒ No If Yes, Claim Number_____
Employer At Time Of Injury:_____ Work Comp. Carrier:_____
Date Of Injury:_____ Status Of Claim: ❒ Open ❒ Closed ❒ Deferred ❒ Denied Date: _____

Is This A Motor Vehicle Injury? ❒ Yes ❒ No If Yes, Claim Number: _____
Auto Insurance Carrier: _____ Agent Name: _____
Phone:( )_____ Date Of Injury: _____
Status Of Claim: ❒ Open ❒ Closed ❒ Deferred ❒ Denied Date:_____

Explain Circumstances Of Injury Or Onset In Detail, State Accident Occurred In, And Date:

_____

_____

_____

Do You Have An Attorney In Regards To This Injury? ❒ Yes ❒ No
Attorney Name:_____ Phone:( ) _____ City: _____

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Health Insurance Information

Patient's Name: _____Date:_____

Primary Insurance: _____

Subscriber (Whose name is the insurance in?) :_____ Relationship to Patient: _____

Employer: _____ Phone: (_____) _____Effective Date:_____

Subscriber ID #: _____GRP#: _____DOB:_____

Secondary Insurance: _____

Subscriber:_____ Relationship to Patient:_____

Employer: _____ Phone: (_____) _____Effective Date:_____

Subscriber ID #: _____GRP#: _____DOB:_____

ASSIGNMENTS OF BENEFIT, CONSENT TO TREAT AND ACKNOWLEDGEMENT THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

1. I hereby assign to Leslie Wallace MS, MPT all money (not to exceed my indebtedness) to which I am entitled for medical expense for such charges incurred with Leslie Wallace.

2. I understand that I will be responsible for the payment of the bill regardless of whether the charges may be covered by insurance or also be the responsibility of some other party. This includes supplies, which I may receive that are not covered by my insurance or other plans.

3. I understand that Leslie Wallace is a Medicare/Medicaid provider for **current** patients only. Leslie will **not** be taking new Medicare or Medicaid patients.

4. If Leslie Wallace engages an attorney to collect the fees and charges owed, I will pay the reasonable attorney fees incurred by Leslie Wallace in any suit, action, or subsequent appeal.

5. I consent to all physical therapy treatments including, but not limited to evaluation, manual therapy techniques, and exercise instruction by Leslie Wallace.

6. By signing below I agree I have read a copy of the **Notice of Privacy Practice**.

7. I hereby agree that it is my responsibility to inform Active Life PT as soon as possible if there has been any changes in my medical or insurance status. Failure to do so may result in future bills.

8. It also my responsibility to inform my provider if I am under the influence of any substance that may effect the safety of the treatment I am receiving, or injure/alter another practitioner's treatment. (ie. Homeopathy)

Patient's Signature _____Date: _____

Parent/Legal Guardian/Rep. Signature_____

Print Rep. Name and relationship to patient_____

Internal use only: Notice of Privacy Practice given to patient, unable to obtain signature:

Active Life signature: _____Date _____

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MEDICAL HISTORY FORM

Name:_____ Date: _____

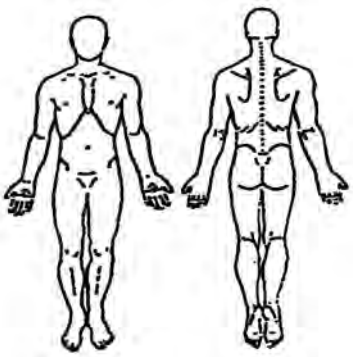
Activities you enjoy or used to enjoy:_____

What is your chief complaint? Please list in order of importance to you.

	PROBLEM	DATE OF ONSET
1		
2		
3		

Recent History and Symptoms

Description of injury or accident, factors that may have played a role in your onset of injury or pain.



Circle the problem areas

Past History

Including all surgeries, hospitalization, head knocks, fractures, and/or major dental work.

Allergies and/or prescription medications/herbs

Are you currently seeing any practitioners? _____

Have you had physical therapy before? _____

Any present treatment for your symptoms? _____

Do you participate in an activity/exercise program? _____

How frequently? _____