Stuart Stark, P.T.
6840 S. Macadam Ave
Portland, OR 97219
ph (503) 936-8640 • fax (503) 248-4730

This letter will inform you of our basic office policies.

BRING TO FIRST APPOINTMENT:

- Doctor's prescription/referral (you may self-refer for PT in Oregon, but if we are billing your insurance company, MOST require a prescription).
- Confidential Patient Information, Health History and Patient Acknowledgement forms filled out & signed.
- Clothes suitable for physical exam – shorts & t-shirt or tank top. On subsequent visits, please bring clothes you're comfortable exercising in.
- **Check or cash for the amount you'll owe. I can also take credit cards.**
- This letter, which you've signed, stating you will respect our office policies.

BILLING POLICY:

- We are happy to bill your insurance. However, it is our office policy to collect from you, at each appointment, whatever amount your insurance company deems is your responsibility.

CANCELLATION & PARKING POLICIES:

- A reminder email for your appointment is made as a courtesy with the understanding that the responsibility to keep the appointment is yours.
- We require 24 hours notice if you need to cancel any appointments. We do charge for late cancellations or no shows as we have the time reserved for you and need time to reschedule.
- There are a few parking spaces available in our parking lot next the building, or on the street.

Sincerely,
STUART STARK, P.T.

I understand and will respect the policies of this office.

_____ _____
Signature Date

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CONFIDENTIAL PATIENT INFORMATION

Patient Name: _____ Birth Date: _____ /_____ / _____
Address: _____ Home Phone: _____
City/State: _____ Zip: _____ Work Phone: _____
Email: _____ Cell Phone: _____
Referring Doc: _____ Doc's Phone: _____

Please complete the following if person other than the patient is responsible for the bill:

Responsible party name: _____ Relationship: _____
Address: _____ Home Phone: _____
City/State: _____ Zip: _____ Work Phone: _____

ACCIDENT REPORT

Is the condition the result of an accident? YES NO
Injury occurred where? Auto Work Other Date of Injury _____ /_____ /_____
Briefly describe if other: _____

INSURANCE BILLING INFORMATION

We MUST have the following information to bill your insurance company

Type of claim: _____ Group/Private: _____ Auto/PIP: _____ Worker's Comp: _____
Insurance Co.: _____ Phone: _____
Address: _____ City/State: _____ Zip: _____
Name of Policyholder: _____ **ID #:** _____
Group/Claim #: _____ Plan/Member #: _____
Agent or contact rep: _____ Phone: _____
Employer of insured: _____ Phone: _____
If work injury, name of employer at time of injury: _____
Attorney if litigating: _____ Phone: _____

I have SECONDARY insurance: YES NO If yes, please fill out a 2nd sheet like this, with the 2ndary insurance information on it and write "2ndary" on it. We will bill both for you.

I authorize Stuart Stark, P.T., to furnish my insurance company all information requested concerning my claim. To the extent of any balances owed to Stuart Stark, P.T., I assign to him all proceeds from my insurance policy or any other policies covering my injuries. I understand and agree that I am financially responsible to Stuart Stark, P.T., for charges not paid by insurers. I agree to pay reasonable court costs and attorney fees incurred by Stuart Stark, P.T., in collecting any unpaid balances owing to him. I agree that balances unpaid 30 days after billing shall result in a service and re-billing charge of 1-1/2% per month.

Signature: _____ Dated: _____ /_____ /_____
Signature of responsible party

HEALTH HISTORY

Date: _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. Thank you!

Name: _____ Age:_____

Occupation: _____

Leisure Activities: _____

Describe your current injury/symptoms: _____

_____

_____

Aggravators: _____

Eases: _____

Pain level (1-10), (also describe: i.e. constant, intermittent, sharp, dull…): _____

_____

Limitations/difficulties: _____

_____

List any healthcare providers you are currently seeing and describe for what reason:

_____

_____

_____

List any surgeries or other conditions for which you have been hospitalized, including approximate date and reason for the surgery or hospitalization.

DATE:	SURGERY/HOSPITALIZATION/REASONS
_____	_____
_____	_____
_____	_____
_____	_____

List any Prescription medication you are taking, including dosage and frequency:

_____

_____

_____

List any Over-The-Counter medications taken in the last week:(including herbal supplements/vitamins & minerals): _____

_____

_____

Have you or anyone in your immediate family been diagnosed as having any of the following conditions: (write S for self or F for family)

Cancer	Thyroid Problems	TB
Heart Problems	Diabetes	Kidney Disease
High Blood Pressure	Arthritis	Anemia
Asthma	Depression	Any Neurological Condition (Stroke, MS …)
Emphysema	Hepatitis	Epilepsy

Other: (or describe any items marked above for self only)

_____

_____

_____

Please circle if any of the following apply:

Unexplained Weight Change	Bowel Dysfunction	Urinary Changes
Night Pain	Numbness	Weakness
Malaise	Nausea/Vomiting	Shortness Of Breath
Dizziness	Fainting	Fever/Chills/Sweats

What are your goals for therapy?

_____

_____

_____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

These policies can be found at www.stuartstarkpt.com/hipaa

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

DATE:

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please print your name Please sign your name

_____ _____
Legal Representative (if applicable) Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Any of the Above
☐ Email Confirmation
☐ Work Phone Confirmation

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:

☐ Cell Phone
☐ Home Phone
☐ Any of the Above
☐ Email
☐ Work Phone