390 Lincoln St, Ste 230
Eugene, OR 97401
Phone: 541-255-2095
Fax: 541-255-2445
info@mobilityprojectpt.com
www.mobilityprojectpt.com
Christine Bodner, PT, DPT, CLT
Ashlee Shupe, PT, DPT
Jacob Winslow, PT, DPT

Dear New Patient,

Welcome to Mobility Project Physical Therapy! We would like to take this opportunity to welcome you to our practice, and to thank you for choosing our clinicians as partners in your healthcare. We look forward to providing you with personalized, comprehensive health care, focusing on wellness, prevention, and evidence-based medicine.

Your first appointment is scheduled for _____

We kindly ask that you arrive **15 minutes** prior to your first appointment to ensure that the intake process doesn't take away from valuable treatment time with your therapist.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. **Please bring your health insurance identification card as well as a photo ID**, **a complete list of all of your medications**, and **the physical therapy referral given to you by your doctor.** Alternatively, you can ask your doctor's office to fax the referral to 541-255-2445.

Our office is located at 4th & Lincoln St. in Eugene. There are two free parking lots available, one across the street on the East side of Lincoln, and one just North of our building, across the railroad tracks on the West side of Lincoln St. Additionally, all nearby street parking is free for 2-hours.

Once again, we would like to thank you for choosing us as your physical therapy provider. We look forward to working with you and helping you get back to the important things in life!

Sincerely,

The Providers and Staff of Mobility Project Physical Therapy

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CONSENT FOR CARE, TREATMENT, & CANCELLATION POLICY

I, the undersigned, do hereby agree and give my consent for Mobility Project Physical Therapy P C to

furnish medical care and treatment to _____ **(name)** that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Mobility Project Physical Therapy PC to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Mobility Project Physical Therapy PC from my insurance carrier or third party payer.

I agree to pay any applicable co-payments, co-insurance, and/or deductibles at the time of service. I understand that insurance benefits may not cover all charges and that I am responsible to pay Mobility Project Physical Therapy PC for all charges not covered by health insurance or third-party payer. There will be a 5% interest charge added to all balances not paid within 30 days of receipt of invoice. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Workers' Compensation. However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
A photocopy of this authorization is to be considered as valid as the original.
By my signature, I authorize Mobility Project Physical Therapy PC, to release all information necessary, including medical records, to secure payment.

_____ **(initial)**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Mobility Project Physical Therapy PC Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Mobility Project Physical Therapy PC to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Mobility Project Physical Therapy Project PC will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom Mobility Project Physical Therapy PC may speak to regarding my treatment. Please list names.

□ spouse _____ □ parent _____
□ child _____ □ other _____

Listed below are individual(s) whom I request restriction regarding my health information.

□ _____ □ Not Applicable

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers or emails you provide us?

□ Yes: □ Home □ Mobile □ Work □ Other: _____ □ Email
□ No

_____ (**initial)**

CANCELLATION POLICY

The Mobility Project is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at 541-255-2095 by 2:00 p.m. on the day prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** Late cancellations/No-show fees are $75 the first time, $100 the second time, and $125 for any subsequent incidents. Late cancellation/No-show fees are due at the time of your next appointment. Please note, these fees will not be covered by insurance. If you miss or cancel three appointments without proper notice, you will be discharged from our care.

To help mitigate missed appointments, we send appointment reminders two days prior to your scheduled visit. Please indicate how you would like to receive them:

□ phone call (#)_____ □ text/sms (#) _____
□ email (@) _____

_____ (**initial)**

SIGNATURE FOR CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care, Treatment, & Cancellation Policy, the Authorization to release all information necessary to secure payment, and the Consent for Use and Disclosure of Health Information.

Patient / Guardian / Responsible Party Signature:

_____
Printed Name

_____ _____
Signature Date

SEXUAL HARASSMENT POLICY

Mobility Project is committed to providing a safe environment for all its employees and patients, free from discrimination of any form, including sexual harassment. We have a zero tolerance policy in place for any form of sexual harassment in the workplace. We treat all incidents seriously and promptly investigate all allegations of sexual harassment and discrimination. Should anyone (patient or employee of Mobility Project) sexually harass another person, patient or employee, the result will be immediate termination from our clinic. A detailed and accurate description of the incident will be documented and permanently kept in the offender's medical chart or employee file. All sexual harassment and discrimination is strictly prohibited whether it takes place within the premises of the clinic or outside.

_____ **(initial)**

DEFINITION OF SEXUAL HARASSMENT

Unwelcome conduct of a sexual nature which makes a person feel offended and/or uncomfortable. It includes situations that create an environment which is hostile, intimidating, or humiliating for the recipient. Sexual harassment can be portrayed physically, verbally, and non-verbally. Examples of conduct or behavior which constitute sexual harassment include, but are not limited to:

- Unwelcome physical contact including patting, pinching, stroking, kissing, hugging, fondling, or inappropriate touching
- Physical violence, including sexual assault
- The use of job-related threats or rewards to solicit sexual favors
- Comments on a worker's appearance, age, private life, etc.
- Sexual comments, stories, and jokes
- Sexual advances
- Repeated and unwanted social invitations for dates or physical intimacy
- Insults based on the sex of the worker
- Condescending or paternalistic remarks
- Display of sexually explicit or suggestive material
- Sexually suggestive gestures
- Whistling, leering, etc.

_____ **(initial)**

By signing this policy, you acknowledge the sexual harassment/non-discrimination terms and conditions put in place by Mobility Project Physical Therapy PC, and agree to conduct yourself in a manner deemed professional and appropriate.

_____

(Printed Name)

_____ _____

(Signature) **(Date)**

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Financial Obligation - Promise to Pay Form

This is a formal agreement to authorize Mobility Project Physical Therapy PC to use the following card information to pay for the medical services provided. This confidential information will be stored in the patient's electronic medical chart on a securely locked computer, and the original copy will be shredded. This information will only be used, should the patient not have a form of payment at the time of check-in. In these cases, the card on file will be charged within 24 hours of the appointment. Should a patient not adhere to our cancellation policy, the late cancellation/no show fee will be charged to this card within 24 hours of the missed appointment.

By signing below, you agree to your financial obligation as a patient of Mobility Project Physical Therapy, and authorize the aforementioned actions to occur, should they be required.

_____

Card Number

_____

Expiration Date CVC Code

_____

Billing Zip Code

_____

Printed Name

_____

Signature Date

Name _____ Date _____
Last **First** **MI**

Mailing Address_____
Street **City** **State** **Zip Code**

Physical Address_____
Street **City** **State** **Zip Code**

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address_____

Social Security Number _____Birth date _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: _____ Spouse/Partner's Name_____ ☐ Divorced ☐ Widowed

Employer _____Employer's Address_____

Primary Care Physician _____Referring Physician _____

Emergency Contact_____Relationship_____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred_____

Claim Number_____ Insurance Company (worker's comp or your auto PIP) _____

Address_____ Claims Adjuster_____ Phone number_____

I verify that the above information is accurate (Signature) _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Health Club/Professional** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ **Radio** advertisement
☐ **Yellow Page** advertisement
☐ Found you on the **Internet**
Website: _____
☐ **TV/Billboard** advertisement
☐ **Publication/Newspaper** advertisement
Publication: _____
☐ **Clinic Sign**
☐ Saw you at an **Event**
Event: _____

NAME:_____ DATE:_____

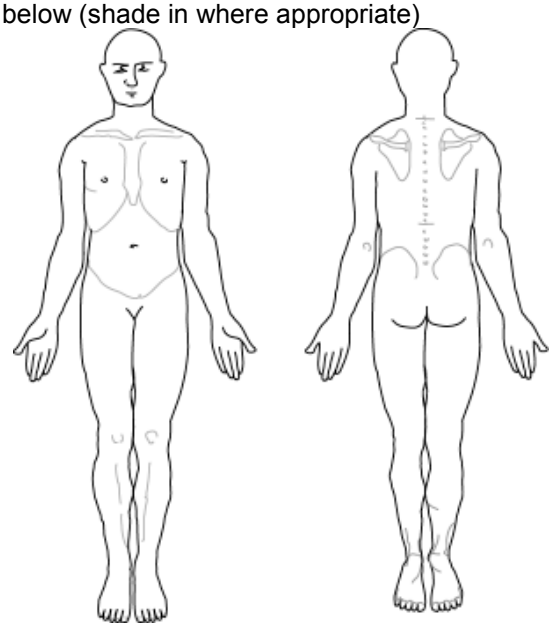
HISTORY OF PRESENT CONDITION

To insure that you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

1) Reason for visit? _____

_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



2) When did your symptoms begin? _____
(Please indicate a specific date if possible)

3) Was the **onset/timing** of this episode?
❒ gradual ❒ sudden
Any previous episodes ❒ Yes ❒ No

4) Which of the following best describes how your injury occurred? *(If you condition is post-surgical, please indicate as per original injury)*

❒ unknown ❒ degenerative process
❒ while Lifting ❒ an incident at work
❒ MVA (car accident) ❒ dental appointment
❒ a fall ❒ during recreation/sports
❒ trauma ❒ overuse (cumulative trauma)
❒ other_____

5) Since the onset, are your symptoms? (Check one)
❒ improving ❒ not changing ❒ worsening

6) Have you had any fall(s) in the past year? ❒ No
❒ Yes, how many times _____ ; ❒ injured ❒ not injured

7) Nature of pain/symptoms (check all that apply)

❒ sharp ❒ aching ❒ constant
❒ dull ❒ periodic ❒ other_____
❒ throbbing ❒ occasional

As the day progresses, do your symptoms: (Check one)
❒ increase ❒ decrease ❒ stay the same

Does the pain wake you at night?

❒ No ❒ Yes If "yes", is it present
❒ while lying down ❒ only when changing positions
❒ both

Do you have pain/stiffness upon getting out of bed in the morning? ❒ Yes ❒ No

8) In what position do you sleep? (Check all that apply)

❒ back, sides, stomach ❒ right side
❒ left side ❒ on stomach
❒ on back ❒ chair/recliner

9) Since the onset of your current symptoms have you had: (Check all that apply)

❒ any difficulty with bowel or bladder function
❒ fever/chills
❒ numbness in the genitals or anal area
❒ numbness
❒ any dizziness or fainting
❒ unexplained weakness
❒ unexplained weight change
❒ night pain/sweats
❒ malaise (vague feeling of bodily discomfort
❒ problems with vision/hearing
❒ none of the above

10) What aggravates your symptoms? (Check all that apply)

❒ sitting ❒ going to/rising from sitting
❒ walking ❒ up/down stairs
❒ standing ❒ squatting
❒ lying down ❒ sleeping
❒ looking up overhead ❒ sustained bending
❒ reaching overhead ❒ reaching in front of body
❒ reaching behind back ❒ reaching across body
❒ repetitive activity _____
❒ household activity _____
❒ recreation/sports including _____
❒ coughing/sneezing ❒ taking a deep breath
❒ talking ❒ chewing ❒ yawning ❒ swallowing
❒ stress

11) What relieves your symptoms? (Check all that apply)

❒ nothing ❒ medication ❒ wearing splint/orthosis
❒ rest ❒ cold ❒ heat
❒ sitting ❒ standing ❒ walking ❒ lying down
❒ stretching ❒ exercise ❒ massage

MEDICATIONS

❒ Consent for Electronic Download of Medication History.
Or
Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

_____

_____

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

❒ aspirin ❒ Advil/Motrin/Ibuprofen
❒ Tylenol ❒ corticosteroids
❒ antihistamines ❒ vitamins/mineral supplements
❒ other_____

OCCUPATION INFORMATION

Occupation_____

❒ employed full time ❒ student
❒ employed part time ❒ retired
❒ self employed ❒ unemployed
❒ homemaker ❒ other_____

Physical activities at work? ___

_____

Are you currently receiving or seeking disability for this condition? ❒ Yes ❒ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level? ❒ Yes ❒ No

LIVING ENVIRONMENT

❒ live alone ❒ live with others
❒ home/apartment ❒ retirement complex (SNF/ICF)
❒ assisted living complex

❒ stairs (railing) ❒ no stairs ❒ uneven ground
❒ stairs (no railing) ❒ ramp ❒ elevator
❒ other _____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Previous Functional Level

❒ **Independent in all activities** (work, community, home, recreation)
❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
❒ Difficulty performing self-care activities
❒ Needed assistance with self-care activities
❒ Difficulty performing household chores
❒ Difficulty with activities in community outside of home

Do you exercise outside of normal daily activities?

❒ 5+ days/wk ❒ 3-4 days/wk ❒ 1-2 days/wk
❒ occasionally ❒ zero

Exercise, Sports/Recreation consisting of _____

_____

What is your general stress level?

❒ Low ❒ Medium ❒ High

Caffeinate Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Alcohol Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Smoking Status?

❒ Never ❒ Former smoker ❒ Current every day
❒ Current some day smoker ❒ Unknown
If smoker how much? _____ ❒ Tobacco ❒ Marijuana

Are you seeing any health care providers other than the physical therapist for this current condition?
(Please list)_____

MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

❒ No diseases or conditions

❒ Cancer ❒ Arthritis
❒ Depression ❒ Osteoporosis
❒ Diabetes ❒ Dental Problems
❒ Circulation/Vascular Problems ❒ Headaches/Migraines
❒ Stroke ❒ Hepatitis
❒ Heart Problems ❒ HIV or AIDS
❒ Pacemaker ❒ Kidney Problems
❒ High Blood Pressure ❒ Lung Problems
❒ Muscle, Joint, or Bone Problems ❒ Stomach Problems

SURGICAL/TESTS HISTORY

❒ No surgeries

Type/Date	*Type/Date*
❒ Shoulder Surgery _____	❒ Hip Surgery _____
❒ Knee Surgery _____	❒ Achilles Tendon Repair _____
❒ ACL Reconstruction _____	❒ Heart Surgery _____
❒ Back Surgery _____	❒ Hip Surgery _____
❒ Joint Replacement _____	❒ Elbow Surgery _____
❒ Ankle/Foot Surgery _____	❒ Neck Surgery_____

Other:_____
Other:_____

Have you had any of the following tests?

❒ none ❒ Bone Scan ❒ Vestibular
❒ x-rays ❒ Arthrogram ❒ Stress X-ray Test
❒ CT Scan ❒ MRI

FAMILY HISTORY

❒ No diseases or conditions

Medical Condition	*relation/onset age if known*
❒ Diabetes	
❒ Alzheimer's	
❒ Heart disease	
❒ Cancer	
❒ Stroke/CVA	
❒ Arthritis	
❒ Rheumatoid arthritis	
❒ Asthma	
❒ Musculoskeletal disease	
❒ Skin disorder	
❒ Osteoporosis	

❒ Mental disorder
❒ Other: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information
Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
Payment. Your health information may be used to seek payment for your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.
Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Company. For example, information on the services you received may be used to support budgeting and financial,
Law Enforcement. Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information
Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.
Information About Treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Your Health Information Rights.
You have certain rights under federal privacy standards. These include:

- The rights to request restrictions on the use and disclosure of your health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your health information
- The right to amend and/or submit corrections to your health information
- The right to receive any accounting of how and to whom your health information had been disclosed * The right to receive a printed copy of this notice

Our Health Information Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Our Rights to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

Requests to Inspect Protected Health Information
As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form request access to your records by contracting the Company's Privacy Officer.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with Mobility Project Physical Therapy, PC or with the Office of Civil Rights of the US Department of Health and Human Services. To file a complaint, you may contact Mobility Project Physical Therapy, PC or the Office of Civil Rights of the US Department of Health and Human Services at:

- Mobility Project Physical Therapy, PC, 390 Lincoln St, Ste 230, Eugene, OR 97401
- Rights.Office of Civil Rights of the US Department of Health and Human Services, 200 Independence Ave. SW, Room 509F Washington DC, 20201

-Effective Date: 8/01/2016