PATIENT INTAKE FORM

Legal Name: _____ Date:_____

Date of Birth: _____ Social Security No._____

Street Address:_____

City:_____State:_____Zip:_____

Mailing Address if Different:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Marital Status: M S D W Sex: M / F

Employer:_____Current Status: Full time / Part Time / Off work

How did you hear about us? (Please specify) Ad: ___ Foot traffic:____ Brochure:____

Website: _____ Friend/Jen Davis DPT Patient: _____ Other:_____

Date of on-set or Injury:_____Date of Surgery:_____

Referring Physician:_____Primary Care Physician:_____

Emergency contact:_____Phone:_____

_____

Insurance: Private Ins?_____Auto?_____What State?_____On the job?_____

Insurance Carrier:_____

Claim Number (Auto or Workers' Compensation)_____

Or Patient's Soc. Sec. No.:_____

Insurance Address:_____

If Private or Auto Ins., name of insured:_____

If On the Job, employer at time of injury:_____

Secondary Insurance:_____I.D.#_____Grp#_____

_____

If patient is a minor (under 18)

Parent/legal guardian Name: _____Phone:_____

Address:_____

Date of Birth:_____Employer:_____Phone:_____

WELCOME TO TREATMENT WITH JENNIFER DAVIS, DPT, dba Oregon Running Clinic

CONSENT TO TREATMENT: I hereby acknowledge that I have been advised that if appropriate to my diagnosis or symptoms, and I hereby consent and agree to the appropriate use of standard physical therapy treatment services. Further, I have been advised that I may refuse such treatment or request that it be provided by a therapist of my gender.

I further understand and agree that for therapy to be effective, I must keep my scheduled appointments unless unexpected circumstances prevent me from doing so. In such an event, I will contact Jennifer Davis as soon as possible. I agree to participate in my therapy and carry out any home exercise program assigned to me. If I have difficulty with any part of my treatment, I agree to discuss it with my therapist.

IF THE PATIENT IS A MINOR OR LEGALLY INCOMPETENT TO CONSENT TO MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE.

FINANCIAL AGREEMENT: The undersigned agrees, whether signing as the patient or on behalf of the patient, that in consideration of the services to be rendered, he/she hereby promises to pay the amount due at time of service. Should the account be referred to an attorney or collection agency for collection and/or suit, the undersigned agrees to pay reasonable attorney's fees and collection expense.

Rate for service varies depending upon the service provided and are based on a 1 hour time allocation. All patient Co-insurance, deductibles and co-pays are due at time of service each visit. $75.00 fee will be charged for no show or cancellation less than 24 hrs.

CONSENT TO USE OF SQUAREUP APPLICATION: I hereby authorize Jennifer Davis to use the "SquareUp" iPhone or iPad application to accept credit card payment at time of service. I further agree that my payment will include a transaction fee of 3.5% + .15 cents per transaction if my credit card information is entered manually and 2.75% per transaction if "swiped." I further consent to an emailed or texted receipt for this type of payment that will include my location at the time of payment.

NON COVERED SERVICES: If you are a member of a HEALTH MAINTENANCE ORGANIZATION, MANAGED CARE PROGRAM, OREGON HEALTH PLAN OR MEDICAID PCO, certain products and services are not covered. If the services you receive are not covered under the guidelines set by your preferred provider contract or by the Oregon Medical Assistance Program, you may be financially responsible to pay for these services.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR AUTHORIZED TO SIGN ON BEHALF OF THE PATIENT, AND HEREBY AGREES TO AND ACCEPTS THE ABOVE TERMS OF SERVICE.

DATE

PATIENT

PATIENT'S AGENT OR REPRESENTATIVE

RELATIONSHIP TO PATIENT