Allison Suran
PT, GCFP, TPS
Therapeutic Pain Specialist
Healing Bridge Physical Therapy

541-318-7041
HealingBridge.com
AllisonSuran@gmail.com

Dear Patient:

Welcome! At Healing Bridge Physical Therapy, I am dedicated to providing you with the best possible care. Please check below to be sure you have the appropriate paperwork.

Before your scheduled appointment, please carefully read and complete the enclosed forms in their entirety, then bring all items to your first appointment. I do not have a waiting room and ***I start my appointments promptly on time.*** If you arrive early there is a break-room/waiting room up the stairs as well as restrooms upstairs.

Note: incomplete and/or missing forms may result in reduced treatment time.

<u>At the time of your appointment you will need:</u>

___ Photo ID (government issued and current)
___ Insurance Cards: Primary and secondary (if applicable)
___ Case/policy number, name of contact person, and contact number if this is a Workers' Compensation or Motor Vehicle Accident claim
___ Prescription from referring provider

<u>HBPT forms:</u>

___ Patient Registration Form
___ HBPT Patient Policies (2 pages)
___ Consent for Treatment
___ Authorization to Text/Email
___ Patient Intake Questionnaire
___ Medication and Supplements List
___ Care Connections 2 page Worksheet
___ Care Connections Work Questionnaire (16 questions)

If you are unable to keep your appointment for any reason, please contact our office as soon as possible. Please feel free to contact us at 541-318-7041 (text or phone call) anytime with your questions or concerns.

LOCATION: The Spectrum Building, 354 NE Greenwood, Suite 105, Bend OR, 97701

The Spectrum Building is located between the Arco gas station on 3rd st, and The Breakfast Club café on 4th St. **PARKING** is in front and back of the building. There is typically more available parking in the lot on Greenwood than in the back alley.

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PATIENT REGISTRATION FORM

Please give your ID and insurance card(s) to the front office for copying. Thank you.

Name: _____ Date: _____

Gender: ☐ Male ☐ Female DOB: _____ SSN: _____

Home Address: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

☐ I authorize HBPT to leave messages at the phone number(s) I have provided concerning treatment, appointments/scheduling, and financial information.

Email Address: _____

Emergency Contact #1 _____ Phone #:_____

Emergency Contact #2 _____ Phone #:_____

I acknowledge the above information is true and correct.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Signature (Parent, if under 18 / Authorized Representative) Date

Relationship to patient: _____

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FINANCIAL POLICY
CANCELLATION/NO-SHOW POLICY
PATIENT PRIVACY POLICY

CANCELLATION/NO-SHOW POLICY

HBPT recognizes that emergencies and scheduling conflicts arise and are sometimes unavoidable. ***HBPT requires 48-hour notice for cancellations. Failure to provide this notice may result in a $50.00 charge.*** This fee is not a covered expense under your insurance policy and will be billed to you directly. You may receive a text and/or phone call reminder notice 48 hours prior to your scheduled appointment. However, this is a courtesy reminder and if our system fails to send this, you are still responsible to know when your appointments are schedule.

FINANCIAL POLICY

Authorization to Bill: I authorize payment of medical benefits directly to Healing Bridge Physical Therapy (HBPT) for services rendered and assign to HBPT all payments for services rendered to me or my dependants.

Insurance Coverage: As a service to our patients, HBPT is glad to directly bill your insurance for services rendered. However, the patient is financially responsible for charges and fees for items and services not covered by insurance. The patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing HBPT with the most current insurance information. HBPT makes every attempt to verify your insurance coverage, although verification of benefits is NOT a guarantee of payment.

Deductibles and Co-Payments: These are a part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect these fees. Co-payments and/or estimated payments based on remaining deductible amounts or coinsurance are due at each visit.

Updates: Please advise us anytime there is a change to your address, telephone, or other contact information. If you are issued a new insurance card or your insurance changes or discontinues mid-treatment, please notify us immediately so there isn't a delay in billing.

Medicare: Our therapists are participating providers with Medicare and we will attempt to bill Medicare as well as any supplemental insurance or commercial Medicare Advantage plan. You are financially responsible for any annual deductible or co-insurance applicable, as well as any amounts for treatment not covered by Medicare. If you have had and any home health during the year in which treatment is sought, you must be officially discharged from home health before Medicare will pay any outpatient benefits.

Workers' Compensation (WC) and Motor Vehicle Accident (MVA): You will be financially responsible for any services not covered by your insurance carrier due to denial of claim, personal injury protection maximum amounts reached and/or expiration of policy benefits. As such, HBPT will collect private health insurance information as a courtesy to you in the event, for any reason, your claim is denied. If

your claim is in a "Deferred" status, is being disputed, or is in litigation, either private health insurance or transfer to a private pay account would be necessary. An attorney "Letter of Protection" for claims being disputed or in litigation will be accepted on a case-by-case basis and will not always be an acceptable form of payment guarantee.

Payment Plans: As a courtesy to patients who cannot pay their account in full every month, HBPT may offer a limited monthly payment plan secured by a valid credit card. Please inquire with HBPT Management about such payment arrangements.

Returned Checks: A $25 fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to our location within 24 hours to replace the full amount of the check as well as the NSF fee.

Collections: If your account becomes grossly past due, we will initiate collection actions. If you do not pay your bill following our internal collection efforts, you account will be sent to an outside collection agency. Additionally, your account may be assessed charges for any collection fees HBPT may incur on your behalf as a result. If your account is sent to a collection agency, you will need to contact them directly to settle your balance.

TIME OF SERVICE DISCOUNT (PRIVATE PAY)

☐ Requires completion of separate Time of Service Discount Policy & Agreement Form

HBPT offers a Time of Service Discount payment option for patients who do not have insurance, have maximized their benefits, or do not give HBPT permission to bill an insurance company. Patient is financially responsible for all physical therapy charges. *Payment is required at the time of service.*

PATIENT PRIVACY POLICY

HBPT is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). We follow all Federal and State laws and regulations regarding PHI and information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law. HBPT's Notice of Privacy Practices is available to all HBPT patients and if requested at any time, a copy will be provided.

I have read and understand the policies outlined above and agree to all conditions contained therein.

_____

Printed Name

_____ _____

Signature Date

_____ _____

Signature (Parent, if under 18 / Authorized Representative) Date

Relationship to patient: _____

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CONSENT FOR TREATMENT

- I voluntarily consent to evaluation and treatment by Healing Bridge Physical Therapy (HBPT).

- I authorize HBPT to release medical information regarding myself and my current condition to my insurance company for the purpose of payment and/or quality reviews, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care.

- In addition to my insurance company and referring physician, I give consent to the following individuals to discuss my appointments and/or treatment on my behalf (e.g., ***spouse, family member <u>OR</u> write N/A***): _____

  _____

I have read and understand the statements above and agree to all conditions contained therein.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Signature (Parent, if under 18 / Authorized Representative) Date

Relationship to patient: _____

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Authorization for Texts and Emails

I understand that texts and emails from Allison Suran, PT/Healing Bridge Physical Therapy are not guaranteed secure.

I _____ agree to receive information about my care
(Patient Name)

Or appointments from Allison Suran, PT by text, email or telephone.

_____ _____
Patient Signature Date

HEALING BRIDGE PHYSICAL THERAPY PATIENT INTAKE QUESTIONNAIRE

Please fill in as thoroughly as possible. **Date**_____

Name _____ **Date of Birth** _____ **Age** _____
Last First MI

SOCIAL HISTORY

Employment / Work (job / school / play) □ Full-Time □ Part-Time Occupation _____

GENERAL HEALTH STATUS

Have you had any major life changes during the past year? (new baby, job change, death of a family member)

□ No □ Yes, please explain _____

_____

List causes of stress (other than pain) in your life:

_____

_____

What do you do to manage your stress? _____

_____

_____

Exercise: Do you exercise beyond normal daily activities and chores? □ No □ Yes Describe the exercise (including days per week, and average # of minutes) _____

_____

_____

Alcohol: How many days per week do you drink alcoholic beverages? _____ If one beer, glass or wine, or cocktail = one drink, how many do you have on days you drink?_____

Smoking: Do you currently smoke tobacco? □ No □ Yes
# of packs/day ____ If smoked in the past, Year quit ____

SYMPTOMS

Severity		Description of the experience
	No pain	Pain free.
1	Minimal	Pain is hardly noticeable.
2	Mild	Feel a low level of pain; aware of the pain only when paying attention to it.
3	Uncomfortable	Pain is troubling but can be ignored most of the time.
4	Moderate	Constantly aware of the pain but can continue normal activities.
5	Distracting	Pain is barely tolerable; some activities limited by pain.
6	Distressing	Pain preoccupies thinking; must give up many activities due to the pain.
7	Unmanageable	Constant pain that interferes with almost all activities; often must take time off work; nothing seems to help.
8	Intense	Severe pain makes it hard to concentrate on anything but the pain; conversation is difficult.
9	Severe	Can concentrate on nothing but the pain; can do almost nothing; can barely talk.
10	Immobilizing	Excruciating pain. Unable to move except to seek immediate help for pain in emergency room. Bedridden.

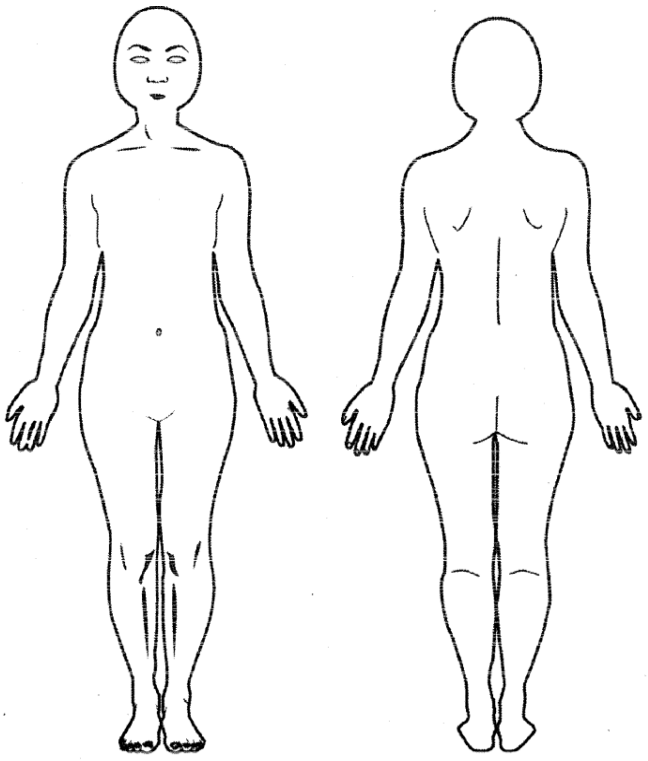
Use the table for reference.

My pain level today is: _____

When it is at its worst, my pain level is: _____

When the pain is at its least, the pain level is: _____

Indicate your symptoms on the diagrams below



TURN OVER FOR PAGE 2 --->

MEDICAL / SURGICAL HISTORY

Check if you have <u>ever</u> had the following, and give approximate DATES and details:

□ Cancer _____

□ Diabetes _____ □ Low blood sugar _____

□ Heart condition _____

□ High blood pressure _____ □ Depression □ Anxiety _____

□ Height _____ Weight _____

□ Arthritis _____ □ Osteoporosis _____

□ Broken bones / fractures (which) _____

□ Seizures / epilepsy _____

□ Allergies (to what?) _____ _____

□ Neurological disorder (MS, ALS etc.) _____

□ Ulcers / stomach problems _____

□ Circulation / vascular problems _____

□ Thyroid problems _____

□ Head injury _____

□ Infectious disease (TB, hepatitis) _____

□ Other _____

_____

Have you ever had surgery? □ No □ Yes, please describe (with dates if possible)

_____

_____

Check if you have had the following <u>within the last year</u>, and provide details:

□ Joint pain or swelling _____

□ Pain at night _____

□ Headaches _____

□ Weakness in the arms or legs_____

□ Loss of balance _____

□ Difficulty walking _____

□ Difficulty sleeping_____

□ Chest pain _____

□ Shortness of breath _____

□ Bowel or bladder problems _____

□ Dizziness or blackouts _____

□ Weight loss or gain _____

□ Cough _____

□ Hearing problems _____ □ Vision problems _____

□ Other _____

For men only: Have you been diagnosed with prostate disease? □ No □ Yes

For women only: Have you been diagnosed with any pelvic or reproductive problems or disease? □ No □ Yes

Use this Space to describe your pain history in detail: (Use another sheet of paper if needed and when possible type your full history to help your medical team understand your complete history.)

At what age did you begin experiencing pain and why?

List with **approximate year/date** all injuries, areas of pain, surgeries, injections, other interventions (PT, Chiropractic, etc) that you have had to manage symptoms and state which symptoms:

What have been the most helpful strategies or interventions you have used to manage your symptoms?

Anything else I should know that can help me help you with your symptoms?

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MEDICATIONS & SUPPLEMENTS LIST

Name: _____ Date: _____

Allergies: _____

IMPORTANT: Include any and all prescribed and over the counter (OTC) items you take regularly. All fields below must be completed in their entirety.

Medication / Supplement Name	**Dosage**	**Frequency**	**Route** (oral, injection, topical)	**Reason**

I verify the above information to be accurate and to the best of my knowledge.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Signature (Parent, if under 18 / Authorized Representative) Date

Relationship to patient: _____

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INSTRUCTIONS

1st Care Connections Patient Worksheet:

If you pain varies, you can check more than one box, indicating what you can do on a "good" day or a "bad" day.

Fill out Section 1, FUNCTIONAL INDEX fully.

Then complete the rest of the sections that are appropriate for your symptoms.

- You do not need to fill out sections that are not applicable, such as TMJ if you do not have jaw pain.
- Any section that you do chose to fill out, please answer all of the questions in that section.
- When in doubt, fill it out.

You DO NOT need to complete the Global Rate of Change – this is for when we do a progress report in the future.

Please remember to put your initials in the bottom right corner on the 2nd page.

2nd Care Connections Worksheet with 16 Questions:

Questions 6 thru 16 ask about "work". If you do not work outside of the home, then include housework, gardening, shopping, and other activities that you do when answering these questions.

CARE CONNECTIONS

PATIENT WORKSHEET

NAME _____ DATE _____

TIME _____ AM/PM ❒ Initial Visit ❒ Discharge Visit

PROBLEM AREA (*Please check one*):

❒ Upper Extremity (A,D) ❒ Lower Extremity (B,F) ❒ Cervical/Thoracic (C,D) ❒ Lumbar (D,F) ❒ TMJ (C,E)

FUNCTIONAL INDEX

PART I: *Answer all five sections in Part 1. Choose the one answer in each section that best describes your condition.*

WALKING

❒ Symptoms do not prevent me walking any distance.
❒ Symptoms prevent me walking more than 1 mile.
❒ Symptoms prevent me walking more than 1/2 mile.
❒ Symptoms prevent me walking more than 1/4 mile.
❒ I can only walk using a stick or crutches.
❒ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

❒ I can do as much work as I want to.
❒ I can only do my usual work, but no more.
❒ I can do most of my usual work, but no more.
❒ I cannot do my usual work.
❒ I can hardly do any work at all (only light duty).
❒ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

❒ I can manage all personal care without symptoms.
❒ I can manage all personal care with some increased symptoms.
❒ Personal care requires slow, concise movements due to increased symptoms.
❒ I need help to manage some personal care.
❒ I need help to manage all personal care.
❒ I cannot manage any personal care.

SLEEPING

❒ I have no trouble sleeping.
❒ My sleep is mildly disturbed (less than 1 hr. sleepless).
❒ My sleep is mildly disturbed (1–2 hrs. sleepless).
❒ My sleep is moderately disturbed (2–3 hrs. sleepless).
❒ My sleep is greatly disturbed (3–5 hrs. sleepless).
❒ My sleep is completely disturbed (5–7 hrs. sleepless).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

❒ I am able to engage in all my recreational/sports activities without increased symptoms.
❒ I am able to engage in all my recreational/sports activities with some increased symptoms.
❒ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
❒ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
❒ I can hardly do any recreational/sports activities because of increased symptoms.
❒ I cannot do any recreational/sports activities at all.

ACUITY (*Answer on initial visit.*)

How many days ago did onset/injury occur? _____days

PART II: *Choose the one answer that best describes your condition in the sections designated by your therapist.*

■ A. UPPER EXTREMITY

CARRYING

❒ I can carry heavy loads without increased symptoms.
❒ I can carry heavy loads with some increased symptoms.
❒ I cannot carry heavy loads overhead, but I can manage if they are positioned close to my trunk.
❒ I cannot carry heavy loads, but I can manage light to medium loads if they are positioned close to my trunk.
❒ I can carry very light weights with some increased symptoms.
❒ I cannot lift or carry anything at all.

DRESSING

❒ I can put on a shirt or blouse without symptoms.
❒ I can put on a shirt or blouse with some increased symptoms.
❒ It is painful to put on a shirt or blouse and I am slow and careful.
❒ I need some help but I manage most of my shirt or blouse dressing.
❒ I need help in most aspects of putting on my shirt or blouse.
❒ I cannot put on a shirt or blouse at all.

REACHING

❒ I can reach to a high shelf to place an empty cup without increased symptoms.
❒ I can reach to a high shelf to place an empty cup with some increased symptoms.
❒ I can reach to a high shelf to place an empty cup with a moderate increase in symptoms.
❒ I cannot reach to a high shelf to place an empty cup, but I can reach up to a lower shelf without increased symptoms.
❒ I cannot reach up to a lower shelf without increased symptoms, but I can reach counter height to place an empty cup.
❒ I cannot reach my hand above waist level without increased symptoms.

■ B. LOWER EXTREMITY

STAIRS

❒ I can walk stairs comfortably without a rail.
❒ I can walk stairs comfortably, but with a crutch, cane, or rail.
❒ I can walk more than 1 flight of stairs, but with increased symptoms.
❒ I can walk less than 1 flight of stairs.
❒ I can manage only a single step or curb.
❒ I am unable to manage even a step or curb.

UNEVEN GROUND

❒ I can walk normally on uneven ground without loss of balance or using a cane or crutches.
❒ I can walk on uneven ground, but with loss of balance or with the use of a cane or crutches.
❒ I have to walk very carefully on uneven ground without using a cane or crutches.
❒ I have to walk very carefully on uneven ground even when using a cane or crutches.
❒ I have to walk very carefully on uneven ground and require physical assistance to manage it.
❒ I am unable to walk on uneven ground.

■ C. CERVICAL/TMJ

CONCENTRATION
- ❒ I can concentrate fully when I want to with no difficulty
- ❒ I can concentrate fully when I want to with slight difficulty.
- ❒ I have a fair degree of difficulty in concentrating when I want to.
- ❒ I have a lot of difficulty in concentrating when I want to.
- ❒ I have a great deal of difficulty in concentrating when I want to.
- ❒ I cannot concentrate at all.

HEADACHES
- ❒ I have no headaches at all.
- ❒ I have slight headaches which come less than 3 per week.
- ❒ I have moderate headaches which come infrequently.
- ❒ I have moderate headaches which come 4 or more per week.
- ❒ I have severe headaches which come frequently.
- ❒ I have headaches almost all of the time.

READING
- ❒ I can read as much as I want without increased symptoms.
- ❒ I can read as much as I want with slight symptoms.
- ❒ I can read as much as I want with moderate symptoms.
- ❒ I cannot read as much as I want because of moderate symptoms.
- ❒ I can hardly read at all because of severe symptoms.
- ❒ I cannot read at all.

■ D. LUMBAR*/CERVICAL/UPPER EXTREMITY

DRIVING
- ❒ I can drive my car or travel without any extra symptoms.
- ❒ I can drive my car or travel as long as I want with slight symptoms.
- ❒ I can drive my car or travel as long as I want with moderate symptoms.
- ❒ I cannot drive my car or travel as long as I want because of moderate symptoms.
- ❒ I can hardly drive at all or travel because of severe symptoms.
- ❒ I cannot drive my car or travel at all.

LIFTING
- ❒ I can lift heavy weights without extra symptoms.
- ❒ I can lift heavy weights but it gives extra symptoms.
- ❒ My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned. (e.g. on a table)
- ❒ My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- ❒ I can lift only very light weights.
- ❒ I cannot lift or carry anything at all.

■ E. TMJ

TALKING
- ❒ I can talk without any increased symptoms.
- ❒ I can talk as long as I want with slight symptoms in my jaws.
- ❒ I can talk as long as I want with moderate symptoms in my jaws.
- ❒ I cannot talk as long as I want because of moderate symptoms in my jaws.
- ❒ I can hardly talk at all because of severe symptoms in my jaws.
- ❒ I cannot talk at all.

EATING
- ❒ I can eat whatever I want without symptoms.
- ❒ I can eat whatever I want but it gives extra symptoms.
- ❒ Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- ❒ Symptoms prevent me from chewing anything other than soft foods.
- ❒ I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- ❒ I cannot chew at all and maintain a liquid diet.

■ F. LUMBAR*/LOWER EXTREMITY

STANDING
- ❒ I can stand as long as I want without increased symptoms.
- ❒ I can stand as long as I want, but it gives me extra symptoms.
- ❒ Symptoms prevent me from standing for more than 1 hour.
- ❒ Symptoms prevent me from standing for more than 30 minutes.
- ❒ Symptoms prevent me from standing for more than 10 minutes.
- ❒ Symptoms prevent me from standing at all.

SQUATTING
- ❒ I can squat fully without the use of my arms for support.
- ❒ I can squat fully, but with symptoms or using my arms for support.
- ❒ I can squat 3/4 of my normal depth, but less than fully.
- ❒ I can squat 1/2 of my normal depth, but less than 3/4.
- ❒ I can squat 1/4 of my normal depth, but less than 1/2.
- ❒ I am unable to squat any distance due to symptoms.

SITTING
- ❒ I can sit in any chair as long as I like.
- ❒ I can only sit in my favorite chair as long as I like.
- ❒ My symptoms prevent me sitting more than 1 hour.
- ❒ My symptoms prevent me sitting more than 1/2 hour.
- ❒ My symptoms prevent me sitting more than 10 minutes.
- ❒ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)

-7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7

Very Much Worse — Unchanged — Completely Recovered

■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition:_____days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____

Case #:

Name: _____ **Date:** _____

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from **0 to 6** to say how much physical activities such as bending, lifting, walking or driving affect or would affect your condition.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity	0	1	2	3	4	5	6
2. Physical activity makes my pain worse	0	1	2	3	4	5	6
3. Physical activity might harm my condition	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
The following statements are about how your normal work affects or would affect your condition. Include housework, gardening and shopping activities in the questions about work.							
6. My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
7. My work aggravated my pain	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6
9. My work is too heavy for me	0	1	2	3	4	5	6
10. My work makes or would make my pain worse	0	1	2	3	4	5	6
11. My work might harm my condition	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work	0	1	2	3	4	5	6