COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. __________
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. __________
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. __________
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell __________
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. __________
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. __________
- I have been offered a copy of this consent form. __________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	__________	Parent / Guardian Signature	__________	Witness Signature	__________
Name	__________	Name	__________	Name:	__________
Date	__________	Date	__________	Date:	__________

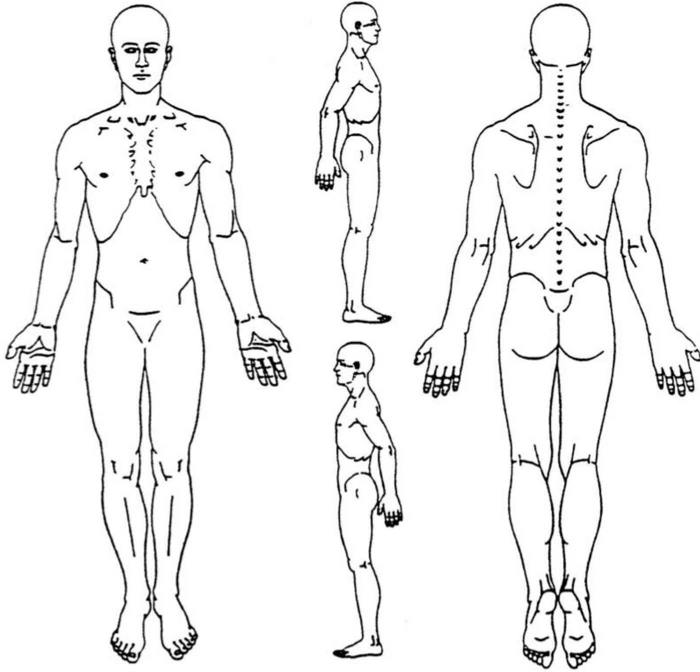
ROGUE
PHYSICAL THERAPY

NEW PATIENT INTAKE FORM

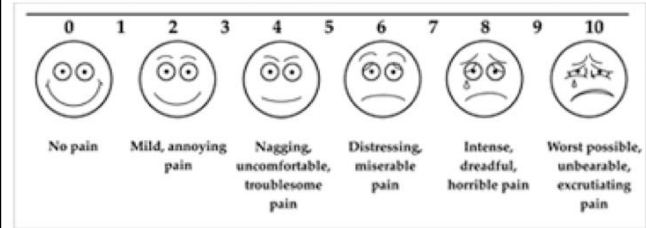
Name__________________________________ Date____________ Birthdate_____________ Age__________

Height_____’_____” Weight___________ Referring Physician____________________________________

Where is your pain? Locate injury site/region.



Please indicate current severity of pain, and highest experienced.



Describe your pain (ie. Dull/Sharp, Deep/Shallow, Achy, tingling, numbness)____

____

Frequency of symptoms (circle best response)

1. Constant (always there 24hrs/day)
2. Intermittent (symptoms fluctuate throughout day)

What percent of the day do you notice your symptoms?

Circle one: 25% 50% 75% 100%

When is the pain at its worst? ____________________________

Is there pain present at night? Y N

What position helps you sleep? ____________________________

When did you first notice pain/dysfunction? Briefly describe onset. ____

____

____

____

____

What makes it feel worse? ______________________________

____

How long will a typical flare up last? ____________________

What makes it feel better? ______________________________

____

How long is relief provided?_____________________________

Have you had surgery for this condition? Y N

If yes, approximate date _________________________________

Have you had injections for this condition? Y N

If yes, approximate date _________________________________

List any diagnostic tests you had had for this condition:

____

When are you scheduled to see your doctor again?

____

Have you been to another medical professional? If so, what helped, what didn’t? ___________________________________

____

Goals for Physical Therapy _______________________________

____

Medical History (check all that apply)

____ Heart Disease _____Diabetes _____ High Blood Pressure _____ Pacemaker _____ Cancer ____ Stroke

____ Tuberculosis _____HIV/AIDS ______Visual Impaired ______ Hepatitis ______ Asthma _____ Arthritis

____ Osteoporosis _____ Seizures _____ Hearing Impaired ______ Scoliosis ______ Kidney Problems

_____Latex allergy _____ Pregnant _____ Fractures ______ Dizziness _______ Metal Implants

Other:

____

Do you smoke? Y N

Please list your medications:

PATIENT CONSENT

Patient Notification Policy
In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and Notice of Privacy Practices, Nathan Lewis, DPT will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment and coordination of your medical care. Furthermore, Nathan Lewis, DPT will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Nathan Lewis, DPT will only disclose your appointment information, such as reminders or cancellations, on voice mail, text message or e-mail, unless you inform us otherwise. This notice refers to Nathan Lewis, DPT as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself." I, the undersigned, hereby authorize Nathan Lewis to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicate below are secure, with password protection used where applicable. If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying Nathan Lewis, DPT if any of the foregoing change. I, the undersigned, hereby authorize Nathan Lewis, DPT to disclose my PHI to the person(s) named below.

Name _____________________ Relationship _________________Phone #__________________
Name _____________________ Relationship _________________Phone #__________________

Patient Signature: _______________________________________Date: ____________________

Consent for Care & Treatment
I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Nathan Lewis, DPT and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages caused. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Nathan Lewis, DPT from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by Nathan Lewis, DPT. I consent to and authorize Nathan Lewis, DPT to administer physical therapy treatment as an Oregon licensed physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist about any health problems or allergies I have, as well as medications I am taking.

Patient Signature: ____ Date: __________________

Financial Responsibility
I understand and am responsible for the agreed fee for service of $100 per 45 minute treatment or if using health insurance, I understand that I am ultimately responsible for fees charged by clinician, and agree to pay any balance not covered, or disallowed by insurance

I hereby authorize release of any personal information necessary to process my claim, including my diagnosis. I understand that this information may become a permanent part of my insurance records. I authorize payments of benefits directly to Nathan Lewis DPT, LLC.

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.

Patient Signature: ____ Date: __________________

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time. This authorization will remain in effect until cancelled. Your card information will be held on file with my credit card processing company, Worldpay with whom I have a HIPPA Business Associate Agreement through WebPT. After scanned into your file this paper will be shredded. For more information about Worldpay security practices, please visit https://www.worldpay.com/en-gb/privacy-policy

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ HSA

Cardholder Name (as shown on card):

____

Card Number:

____

Expiration Date (mm/yy):

Three Digit Code (on back of card)

____

Cardholder ZIP Code (from credit card billing address):

____

I, ____, authorize **Nathan Lewis DPT LLC** to charge the card above for copays/therapy sessions /no show fees/etc., for services provided to

____. I understand that my information will be saved in my file for future transactions on my account.

____

Signature Date

PATIENT INFORMATION & FINANCIALS

PATIENT INFORMATION

Name____________________ Date of birth ___________ Social security number___________

Address ____

CITY STATE ZIP

Home phone #_____________ Cell phone #______________ Okay to leave a message? _____

Email _______________________________ Preferred contact method ____________________

Whom to contact in case of an emergency _____________________ _____________________

NAME PHONE #

Responsible Party ___________________________ Relationship to Patient _______________

FINANCIAL INFORMATION

Name of person responsible for this patient_____________________Relationship__________

Address & Demographics if different than patient ____________________________________

ADDRESS CITY STATE ZIP

____

DATE OF BIRTH CONTACT PHONE NUMBER EMAIL ADDRESS OKAY TO LEAVE A MSG?

If you have insurance, it is your responsibility to contact your insurance company to find out what portion of the fees will be covered by your plan. If you would like me to bill your insurance company for you, please provide the following information and a copy of your insurance card.

Name of Insurance Company ___________________________Plan Type_________________

Subscriber's Name _____________________________________Subscriber's D.O.B_________

Subscriber's I.D. #______________________________________Group I.D. #______________

Has the yearly deductible been met? _____________________Co-pay Amount ____________

Secondary Insurance Company _________________________Plan Type ________________

Subscriber's Name _____________________________________Subscriber's D.O.B_________

Subscriber's I.D. #______________________________________Group I.D. #______________