RestorePDX

Date:

Patient Information

Patient First Name: | Middle Name: | Last Name:

Social Security #: | DOB: | Gender: ☐ Male ☐ Female

AKA/Preferred Name: | Email:

Home Address:

City: | State: | Zip Code:

Please list your mailing address if different from above:

Phone Numbers: *Please check the preferred contact phone number for you.*

☐ Home: | ☐ Work: | ☐ Cell:

Do you authorize us to leave detailed phone messages on your preferred contact number?

Race/Ethnicity: | Preferred Language: | Interpreter: ☐ Yes ☐ No

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Separated

Education: ☐ 12th Grade ☐ College | Student Status: ☐ Full-time ☐ Part-time ☐ None

Primary Care Physician/PCP

PCP First Name: | PCP Last Name: | Phone: | Fax:

Guarantor Information *(if other than patient)*

Guarantor Name: | Relationship: | Address:

Insurance Information

Carrier Name 1: | ☐ Medical ☐ WC ☐ MVA

ID#: | Group #: | Group Name:

Subscriber: ☐ Self ☐ Spouse ☐ Child | Name:

Carrier Name 2: | ☐ Medical ☐ WC ☐ MVA

ID#: | Group #: | Group Name:

Subscriber: ☐ Self ☐ Spouse ☐ Child | Name:

Emergency Contact Information

Name: | Phone: | Relation:

Name: | Phone: | Relation:

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We would like to thank the person/people that referred you to RestorePDX. Thus, we would appreciate you answering just a few more questions.

How were you referred to RestorePDX today?

How did you first hear about RestorePDX?

☐ Word of Mouth — ☐ Family member ☐ Friend ☐ Coach or Trainer

☐ Advertising — ☐ Brochure ☐ Radio ☐ TV ☐ Magazine

Please specify which ad, channel, station or magazine:

Past Event or Lecture (which event):

Internet

☐ Browser — Please identify which search engine used: ☐ Bing ☐ Google ☐ Firefox ☐ Internet Explorer

☐ Facebook — Are you following our page? ☐ Yes ☐ No

☐ YouTube

☐ Web Advertisement — ☐ Google Ad ☐ Video Ad

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Authorization for Release of Health Information

Please answer the following three questions regarding the release and disclosure of your medical and billing information.

Do we, RestorePDX, have your permission to release your medical information to your healthcare providers? ☐ Yes ☐ No

Do we, RestorePDX, have your permission to obtain your medical information from your healthcare providers? ☐ Yes ☐ No

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please list ALL.

Name of Person	Relationship	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Printed Patient Name

Patient's Date of Birth

Signature of Patient

Date

Signature of Parent/Guardian

Relationship to Patient

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Welcome to RestorePDX! The trust and confidence you have placed in us as a part of your healthcare team is appreciated. In return, we are committed to providing you with the best health care possible.

Visiting Our Office

We are located at 9925 SW Nimbus Avenue, Suite 100, Beaverton, Oregon 97008. To make or change your appointment, please contact the clinic at 503-535-8302. To better serve our patients who may be waiting to see their provider, we require a 24-hour notice if you need to cancel or change your Appointment. If you find yourself 15 or more minutes late for your appointment, please call the office to reschedule. If you are planning to use insurance for your services, we must receive your insurance information at least 2 business days prior to your appointment.

Appointment Requirements

1. **Please complete your new patient packet prior to your arrival. We request that our new patients arrive 20 minutes prior to their scheduled appointment time.**
2. **Please arrive at your scheduled arrival time to ensure you are seen in a timely manner. We respect that your time is valuable and will make every effort to see you at your appointment time. We apre- ciate your patience if there is a delay due to unexpected circumstances.**
3. **CO-PAYMENTS ARE DUE AT THE TIME OF YOUR OFFICE VISIT (HMO and PPO patients if it applies). We accept cash, personal checks, and debit and credit cards.**
4. **If you have imaging of the treatment area within the last 3 years, the imaging and imaging reports must be provided to our office prior to the appointment time. Images must be in a CD format. If no imaging is provided, we will need to reschedule your appointment.**

In Case of Emergency

If you have a life-threatening medical emergency, please call 911.

Our clinic is not equipped with an on-call physician. If you have non urgent requests of your provider please contact our office staff at 503-535-8302 and a message will be promptly relayed to your provider who will respond when they are next in clinic, typically within 2-3 business days.

Thank you for choosing RestorePDX for your care. Please call us any time with your questions or concerns.

We look forward to a long and healthy relationship with you.

The Team at RestorePDX

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General Clinic Policies

Communication

It is not the policy of our office to manage medical care via email or text message. While these can be efficient methods of communicating, we believe we can best serve you face to face or over the phone if necessary. To that end our providers do not communicate over email. Please understand that all communication with staff via email is not HIPAA compliant and any information transmitted via email is in an unsecured format.

It is not our policy to conduct phone consults or otherwise give medical advice over the phone. If such a consult is requested, you will be responsible for a telephone visit fee, which is not covered by insurance. From time to time your provider may contact you by phone for a brief exchange of medical information. There is no fee for such a service.

Imaging and Lab Review

Your initial visit will include a complete discussion of your health history and current symptoms. Physical exams relating to your symptoms will likely be performed in this visit. Your provider may order labs or imaging in this appointment, which will be released and discussed with you in a follow-up office visit. It is not the policy of our clinic to release labs or imaging without interpretation by your provider or over the phone. In this follow up appointment, your provider will then make a treatment plan tailored to you and answer any questions you may have.

Disclosure of Ownership

The following physician is an owner and has a vested interest in Clearview MRI: Rahul Desai MD. You have the right to choose the provider of your healthcare services, therefore you have the option to use a healthcare facility other than Clearview MRI. You will not be treated differently by your physician if you choose to obtain healthcare services at ta facility other than Clearview MRI. If you have any other questions concerning this notice, please feel free to ask you physician or any manager at Clearview MRI.

Prescriptions

If you need a prescription refill please call your pharmacy first. They will fax us your request or send it electronically. In order for your provider to make an informed decision with ample time to review your history please provide at least 2-3 business days' notice for your refill.

Records Requests

For records requests for other providers we will do our best to get these processed within 7 business days. However, please keep in mind that common standards allow for 30 days to fulfill these requests. Letters of medical necessity will be completed within 7 business days.

I acknowledge that I have read and understand the general clinic policies for RestorePDX and have discussed any concerns or questions I have with the office staff.

Signature Date:

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Financial Policy, Assignment of Benefits, and Receipt of Notice of Privacy Practices

If you have insurance, RestorePDX will gladly process your claim; however, we require that your estimated portion be paid when services are rendered. If you are not covered by insurance, we will provide an estimate of the cost of your care including anticipated charges based on the recommended treatment plan. If your treatment plan changes, you may be asked to agree to a new estimate, which may vary due to a variety of factors.

If you are a self-pay patient, or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due in a reasonable time. For payment options and further information on our billing process, please speak with our Business Office.

Please Initial:

_____ I request that payment of authorized insurance benefits be made on my behalf to RestorePDX for all pharmaceuticals, tests, procedures, equipment, supplies, and physician/nursing services (including major medical benefits) for services provided to me by RestorePDX.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to RestorePDX, such as my insurance carrier, state, federal accreditation agency, or other medical entity.

_____ It is my responsibility to notify RestorePDX of any changes in my healthcare coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

_____ I understand that I am financially responsible to RestorePDX for any charges not covered by my health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by RestorePDX and/or my health care insurer. If the submitted claims, or any part of them, are denied for payment, I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical series received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services.

_____ I understand that there is a $25.00 charge for all returned checks.

_____ I understand there is a $50.00 fee for all missed or cancelled appointments that are not cancelled before 24 hours of the scheduled appointment time.

By signing this document, I acknowledge that I have been made aware of RestorePDX's. Notice of Privacy Practices, as it is required by the Health Insurance Portability and Accountability Act (HIPAA), to ensure that I have been made aware of my privacy right as well as understanding the billing process. I have read, and if requested received a copy of, the above statement and Privacy Practices and accept the terms. A duplicate of facsimile transmission of this statement is considered the same as the original.

This assignment/acknowledgement will remain in effect unless revoked by me in writing.

Signature Date:

Print Name of Insured/Parent/Guardian

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Ultrasound Evaluation

During your office visit, your provider may choose to perform an ultrasound evaluation. This evaluation is a tool for the provider to assess your injury/pain in real time. This evaluation can be key in obtaining a correct diagnosis and an optimal treatment plan for your pain.

The ultrasound evaluation is an additional charge that is billable to your insurance company. This is a diagnostic imaging procedure and will fall under such category with your insurance carrier. Diagnostic imaging may be subject to copay, coinsurance, deductible, etc. as specified in your insurance plan. It is ultimately the patient's responsibility to know their insurance coverage, as every plan through every insurer differs.

For your convenience the ultrasound can be done in addition to your office visit, on the same day. If you so choose, the ultrasound evaluation can also be scheduled for a different date and time.

The type of ultrasound needed will be determined by your provider and will depend upon many factors including, but not limited to, area of the body and the symptoms you are experiencing. Ultrasound pricing is as follows:

Limited Ultrasound Examination: $89.00 Full Ultrasound Examination: $308.00

By signing this agreement, you acknowledge that you have been informed that the ultrasound evaluation will incur a charge in addition to your office visit.

X

Patient Signature:

Date

Phone 503-535-8302 Fax 503-416-8732
9925 SW Nimbus Avenue, Suite 100 Beaverton, OR 97008

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Background

Patient Name: DOB:

Were you referred to our office? □ No □ Yes – If yes, by whom:

Please list top 3 current and ongoing problems in order of priority and treatments tried:

Problem	Prior Treatment/Approach	Mild	Moderate	Severe
1.				
2.				
3.				

Pharmacy Information

Name of pharmacy Address/Zip code Phone Fax

Care Team - *Please list all other physicians involved in your care including name, role, phone, and fax #*

Name Role/Specialty Phone Fax

Allergies – *Please list all allergies and reactions (e.g., hives, rash, nausea, etc.)*

Allergy: Reaction(s): (please specify severity) □ No known drug allergies

□ No known food allergies

Have you ever had any reactions to anesthesia? □ No □ Yes- please list reaction:

Medical History – *Please mark all that apply*

□ Arthritis | Type:	□ Seizures	□ Tendonitis/Bursitis
□ Cancer | Type:	□ Sleep Apnea	□ Liver Disease
□ Diabetes | □ Type 1 □ Type 2	□ Emphysema/COPD	□ Fibromyalgia
□ Bleeding Disorders	□ Heart disease	□ Kidney Disease
□ High blood pressure	□ Mitral valve prolapse	□ Stroke/TIA
□ Mental Illness- please specify:		□ Other:

Surgical/Hospitalization History – *Please list all surgeries/hospitalizations and approximate date*

□ I have never been hospitalized

□ I have never had surgery

Family History – *Please list all illnesses in immediate family*

Social History

What is your form of employment? □ I am currently unemployed

Do you have children? □ No □ Yes – If yes, how many?:

With whom do you live: □ Spouse □ Children □ Mother □ Father □In-law's □ Brother □ Sister □ Partner □ Roommates □ Other:

Alcohol use: Type: Number of drinks per week: □ I do not drink Alcohol

Do you have a history of heavy drinking? □ No □ Yes - If yes, Quit Date:

Do you consume caffeine? □ No □ Yes – If yes, # drinks/day:

Do you smoke or use tobacco/chew? □ Never □ Current Amt. Per Day If yes, Quit Date:

Did you or do you use any street drugs? □ Never □ Current Amt. Per Day If yes, Quit Date:

Have you ever OVER-used narcotics or prescription medication? □ Yes □ No

Have you ever used narcotic or prescription medication for conditions other than pain or what it was intended for? □ Yes □ No

Do you have a history of mental illness? □ No □ Yes – If yes, please specify:

Do you exercise? □ No -If no, does your pain limit exercise? □ Yes □ No
□ Yes -If yes, what type? □ strength training □ stretching □ Anaerobic (cardio)
If yes- how many hours per week? □ 0-5 □ 6-10 □ 11-15 □ 15+

Medications & Supplements – *Please list ALL medications you are <u>currently</u> taking including dose*

Medication	Dose/Frequency	Reason	Prescriber

Medications & Supplements tried for current complaint but <u>no longer</u> taking:

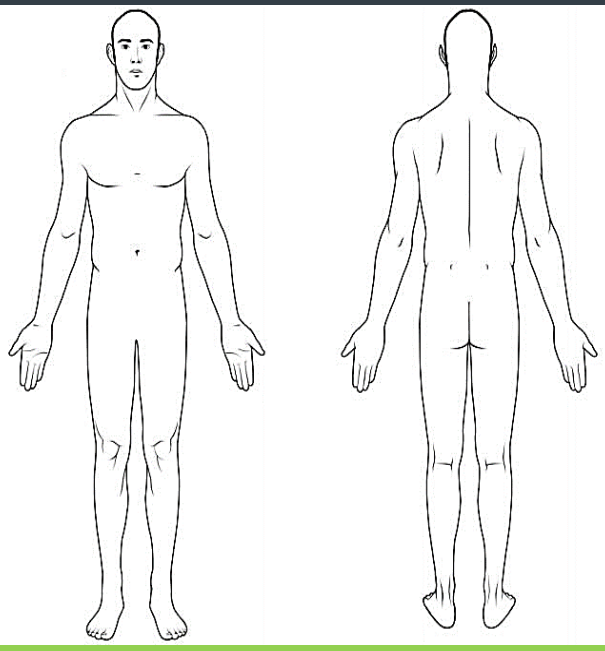
Medication	Dose/Frequency	Reason Stopped	Prescriber

Please mark the picture where your pain is located:

Patient Name: _____

DOB:

Please rate your pain intensity on a scale of 0 to 10, where 0=no pain and 10= incoherent, passing out, the worst pain possible. Circle the appropriate number below:



No pain	0	1	2	3	4	5	6	6	7	8	9	10	Worst Pain

Pain Description

Do you have any pain, numbness or tingling? □ I have pain □ I have numbness/tingling □ I have neither

What is the most painful/numb area you would like us to address primarily?

When did your pain start?

Are you currently working? □ Full time □ Part Time □ I am not currently working - If so, when was your last working date? - Please specify

Was there a specific injury within hours of the onset of your pain? □ No □ Yes
- If yes, please select all that apply: □ Motor Vehicle Accident □ Work Injury □ Fall □ Lifting □Unknown

Was this spontaneous onset (no specific injury)? □ Yes □ No

Have you ever been to the ER or Urgent Care for this problem?

Have any other doctors treated you for this problem?

Details of Pain Symptoms

How severe is the problem for you? □ Mild □ Moderate □ Severe

Is the problem: □ Getting Better □ Getting Worse □ Unchanged

What alleviates your pain? □Sitting □ Standing □ Lying down □ Stretching □ Other (Please Specify):

What aggravates your pain? □ Sitting □ Standing □ Lying down □ Stretching □ Other (Please Specify):

Have you experienced any of the following? □ Bowel/Bladder control issues

□ Numbness in legs/feet □ Weakness in legs/feet □ Weakness in arms/legs □ Numbness in arms/hands

Prior Treatments Tried

Treatments Tried	Helpful? – please circle	Date Started	Date Stopped	Adverse reactions
Injection(s)	Yes No			
Brace(s)	Yes No			
Physical Therapy	Yes No			
Chiropractor	Yes No			
Acupuncture	Yes No			
TENS	Yes No			
Biofeedback	Yes No			
Psychological Help	Yes No			
Other:	Yes No			
□ I have not had any prior treatments for my current complaints				

Please select any prior medications you have tried:

□ Ibuprofen/Advil	□Aleve/Naproxen	□ Lyrica	□ Fentanyl	□ Oxycodone	□ Valium
□ Ultracet	□ Celebrex	□ Mobic	□ Dilaudid	□ Hydrocodone	□ Tramadol
□ Flexeril	□ Gabapentin	□ Skelaxin	□ OxyContin	□ Other (Please Specify):	

Prior Imaging/Diagnostic Tests

Imaging/Test	Body Part	Facility	Month & Year
MRI			
X-Ray			
CT Scan			
Ultrasound			
EMG/Nerve Conduction Study			
Bone Scan			
Other:			
□ I have not had any prior imaging or diagnostic tests			

Please list any clinics you have been to outside of RestorePDX for your pain:

Are you currently under a pain contract with any providers? □ No □ Yes – If yes, Whom?

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Please indicate any that you have experienced in the last six months:

General	**Skin**	**Urinary**
☐ Fatigue	☐ Rashes/Sores	☐ Pain With Urination
☐ Insomnia	☐ Easy Bruising	☐ Loss of Urine
☐ Stress	☐ Itching	☐ Odor Changes
☐ Weight Loss/Gain	☐ Dryness	☐ Frequency/Urgency
☐ Snoring	☐ Thinning of Hair	☐ Incomplete Emptying
☐ Mental Fog	☐ Changes in Nails	**Hormones**
☐ Recent Illness	**Psychiatric**	Changes in Menses
Neurologic	☐ Mood Changes	☐ Painful/Heavy Menses
☐ Dizziness	☐ Anxiety	☐ PMS
☐ Excessive Sleepiness	☐ Depression	☐ Low Sex Drive
☐ Fainting	☐ Thoughts of Self Harm	☐ Vaginal Dryness
☐ Headaches	☐ Increased Alcohol/Drug Usage	☐ Hot Flashes/ Night Sweats
☐ Seizures/Tremor	**ENT**	☐ Lower Muscle Mass
☐ Mental Changes	☐ Nose Bleed	**Chest/Lung**
☐ Memory Changes	☐ Sinus Congestion	☐ Cough
Eyes	☐ Sore Throat	☐ Chest Congestion
☐ Eye Pain	☐ Bleeding Gums	☐ Wheezing
☐ Light Sensitivity	☐ Lump in Throat	**Musculoskeletal**
☐ Changes in Vision	☐ Ringing in Ears	☐ Back Pain
☐ Dryness/Tearing	☐ Mouth/Jaw Pain	☐ Neck Pain
Cardiovascular	**Digestive**	☐ Joint Pain:
☐ Chest Pain	☐ Abdominal Pain	
☐ Irregular Beating	☐ Constipation	☐ Numbness
☐ Foot/Hand Swelling	☐ Diarrhea	☐ Tingling/Burning
☐ Cold Hands/Feet	☐ Bloating	☐ Weakness
☐ Short of Breath	☐ Heartburn	☐ Change in Exercise Tolerance
☐ High Blood Pressure	☐ Nausea/Vomiting	
☐ Low Blood Pressure	☐ Loss of Bowel Control	