Laila Deardorff, LLC
Lake Oswego, OR 97035
laila@lailadeardorff.com

OFFICE POLICIES

I look forward to seeing you at your first appointment. This letter will inform you of my basic office policies.

BRING TO FIRST APPOINTMENT:

- Doctor's prescription/referral (you may now self-refer for PT in Oregon)
- Confidential Patient Information, Health History, Patient Acknowledgement forms filled out & signed.
- Clothes suitable for physical exam – shorts & t-shirt or tank top. On subsequent visits, please bring clothes you're comfortable exercising in.
- **Check or cash for whatever amount you'll owe. I can also take credit cards but there is an additional 2.75% fee.**
- This letter, which you've signed, stating you will respect my office policies.

BILLING POLICY & YOUR INSURANCE BENEFITS:

- It is my office policy to collect from you, at each appointment and I will not be billing your insurance. I will give you a coded receipt so that you can submit to your insurance for reimbursement if you request.

CANCELLATION & PARKING POLICIES:

- A reminder email/phone call for your appointment is made only as a courtesy with the understanding that the responsibility to keep the appointment is yours.
- I require 24 hours notice if you need to cancel any appointments. I do charge for late cancellations or no shows; I have the time reserved for you and need time to reschedule.
- I have plenty of parking space available in the turn around in front of the house.

Sincerely,
Laila Deardorff, M.S.P.T.

I understand and will respect the policies of this office.

____ ________________

Signature Date

Laila Deardorff, LLC
Lake Oswego, OR 97035
laila@lailadeardorff.com

CONFIDENTIAL PATIENT INFORMATION

Patient Name: ____ Birth Date: ___ /____/ _______

Address: ____ Home Phone: ________________

City/State: __________________________________ Zip: __________ Work Phone: _________________

Email: ____ Cell Phone: _________________

Referring Doc: ____ Doc's Phone: _________________

Primary Care Physician: _______________________________________ Doc's Phone: _________________

Occupation: ____

Status: Employed ___________ Retired _________ Not Working __________ Student _______________

Please complete the following if person other than the patient is responsible for the bill:

Responsible party name: _____________________________________ Relationship: ________________

Address: ____ Home Phone: _______________

City/State: _________________________________ Zip: ____________ Work Phone: _______________

ACCIDENT REPORT

Is the condition the result of an accident? YES NO

Injury occurred where? Auto Work Other Date of Injury: _____ /_____ /_____

Briefly describe if other:____

____

Signature: ____ Dated: _____ /_____ /_____
Signature of responsible party

HEALTH HISTORY

Date: ______________

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. Thank you!

Name: ____ Age: ______________

Occupation: ____

Leisure Activities: ____

Describe your current injury/symptoms: ____

____

____

Aggravators: ____

Eases: ____

Pain level (1-10), (also describe: i.e. constant, intermittent, sharp, dull…): ______________________

____

Limitations/difficulties: ____

____

List any healthcare providers you are currently seeing and describe for what reason:

____

____

____

List any surgeries or other conditions for which you have been hospitalized, including approximate date and reason for the surgery or hospitalization.

DATE: SURGERY/HOSPITALIZATION/REASONS

________ ____

________ ____

________ ____

________ ____

List any Prescription medication you are taking, including dosage and frequency:

____

____

____

List any Over-The-Counter medications taken in the last week:(including herbal supplements/vitamins & minerals): ____

____

____

Have you or anyone in your immediate family been diagnosed as having any of the following conditions: (write S for self or F for family)

Cancer	Thyroid Problems	TB
Heart Problems	Diabetes	Kidney Disease
High Blood Pressure	Arthritis	Anemia
Asthma	Depression	Any Neurological Condition (Stroke, MS ...)
Emphysema	Hepatitis	Epilepsy

Other: (or describe any items marked above for self only)

____

____

____

Please circle if any of the following apply:

Unexplained Weight Change	Bowel Dysfunction	Urinary Changes
Night Pain	Numbness	Weakness
Malaise	Nausea/Vomiting	Shortness Of Breath
Dizziness	Fainting	Fever/Chills/Sweats

What are your goals for therapy?

____

____

____

____

____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR COMMUNICATION

These policies can be found at www.lailadeardorff.com.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

Patient Signature: ____ Date____________

Authorized Representative/Guardian Signature:_____________________________ Date____________

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Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Laila Deardorff, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Laila Deardorff, LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

I do not consent to any voicemail, email or texting communication.

I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):

- o Email
- o Text
- o Voicemail

I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):

- o Email
- o Text
- o Voicemail

E-mail address you are consenting to communicate through: ______________________________

Phone number you are consenting to communicate through: ______________________________

Patient Signature: ____ Date: ____________

Authorized Representative/Guardian Signature: _____________________________ Date: ____________