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REFLEX CONFIDENTIAL PERSONAL INFORMATION FORM

Welcome to Reflex! In order to best serve you, please complete the following in as much detail as possible.

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Age: _____ Date of Birth: _____

Last Four Digits of your SSN (Required for billing & Insurance processing): _____

Gender:
❒ Male
❒ Female
❒ Other

Relationship Status:
❒ Single
❒ Married
❒ Other

Preferred Language:
❒ English
❒ Spanish
❒ Other: _____

Ethnicity:
❒ Non-Hispanic or Latino
❒ Hispanic or Latino
❒ Mexican American
❒ Cuban
❒ Puerto Rican

Race:
❒ White
❒ Asian
❒ Somoan
❒ Pacific Islander
❒ Other: _____
❒ Black or African American
❒ American Indian/Alaska Native
❒ Native Hawaiian

Address: _____

Apt/Suite/Unit: _____ City: _____ State: _____ Zipcode: _____

Telephone # (Cell): _____ (Home): _____ (Work): _____

E-mail Address: _____

Preferred Method of Contact: ❒ Phone ❒ E-mail

How would you like to be reminded of appointments? ❒ Phone Call ❒ Text Message ❒ E-mail

Emergency Contact: _____ Relationship: _____ **Phone**: _____

Insurance Information

Please provide the Front Desk staff with your insurance card(s) so that we may keep a photocopy on file

Primary Insurance Co: _____ Policy Holder's Name: _____

Relationship to Insured: ❒ Self ❒ Spouse ❒ Child ❒ Other: _____

Subscriber/Member ID#: _____ Group #: _____

Secondary Insurance Co: _____ Policy Holder's Name: _____

Relationship to Insured: ❒ Self ❒ Spouse ❒ Child ❒ Other: _____

Subscriber/Member ID#: _____ Group #: _____

Are you on "Medicare Working Age" (on Medicare but still working)? ❒ Yes ❒ No

By Signing Below, I verify that all of the above information is correct and true to the best of my knowledge

_____ _____

Patient/Authorized Individuals Signature Date Signed

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REFLEX CONFIDENTIAL HEALTH HISTORY INTAKE FORM

Full Legal Name Last Name: _____ First Name: _____ Middle Initial: _____

How did you first hear about our clinic?_____

If Radio -- Please circle one: OPB/NPR/Jazz Radio 750/102.9 The Game (Canzano) KXL 101.1

Who is your Primary Care Provider? _____ **Phone #:** _____

Reflex will share your records (including chart notes and outcomes) with your PCP, unless otherwise requested.

❒ No, I do not want my records from Reflex shared with my PCP.

Have you been diagnosed or treated for any of the following conditions? (check all that apply)

❒ Arthritis
❒ Blood Clots (DVT)
❒ Blood Disorders
❒ Cancer
❒ Other: _____
❒ Diabetes
❒ HIV/AIDS
❒ Heart Disease
❒ Hypertension
❒ Kidney Failure / Dialysis
❒ Stroke
❒ Transplant Surgery
❒ Psoriasis (You or family member)

List previous surgeries NOT knee related: _____

Do you have any known food and/or medication allergies? ❒ Yes (please indicate below) ❒ No

_____

_____

Please list <u>all</u> prescription medications you are currently taking:

_____

_____

Have you <u>ever</u> taken any of the following medications to control your knee pain? ❒ Yes ❒ No

If yes, please write how much and how often.

❒ Tylenol _____ When: _____
❒ Advil _____ When: _____
❒ Ibuprofen _____ When: _____
❒ Motrin _____ When: _____
❒ Asprin _____ When: _____
❒ Other: _____ When: _____

Please rate the effectiveness of the medication(s) you are taking for you knee pain:

❒ Never effective
❒ Usually effective
❒ Sometimes effective
❒ Always effective

Are you taking any supplements? ❒ Yes ❒ No

If yes, please check the supplements you are regularly taking and note the amount you are taking

❒ Fish Oil _____
❒ Glucosamine/Chondroitin/MSM _____
❒ Multi-Vitamin _____
❒ Canabrex _____
❒ Magnesium _____
❒ Other: _____ _____

What is your smoking status? *(if currently smoking, how many packs per day on average?)*

❒ I currently smoke _____ packs per day
❒ Former smoker, year quit: _____
❒ Non-smoker

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How long have you been experiencing knee pain?

Right Knee: _____

Left Knee: _____

Please list any prior knee injuries, arthorscopies, or surgeries below: *(please include the year)*

Right Knee: _____

Left Knee: _____

Have you ever had Hyaluronic Acid (HA) Knee injections?

❒ Right Knee
Approx. date of last injection: _____

❒ Left Knee
Approx. date of last injection: _____

Brand of Hyluronic Acid (HA) Injection:

❒ Euflexxa

❒ Synvisc

❒ Orthovisc

❒ Durolane

❒ Other: _____

Have you ever had Cortisone Knee injections?

❒ Right Knee
Approx. date of last injection: _____

❒ Left Knee
Approx. date of last injection: _____

Have you ever participated in a knee physical therapy program?

❒ Yes
Approx. date of last visit: _____

❒ No

Have you ever been fitted for or used an off-loading knee brace? *(if yes, indicate date you were fit)*

❒ Right Knee _____

❒ Left Knee _____

Have you been evaluated for knee pain by an orthopedic surgeon? ❒ Yes ❒ No

If 'yes', what is the *date* of the evaluation and orthopedic surgeons name?

_____

If 'yes', what was the recommendation (i.e. arthoscopy, meniscal/ACL repair, knee replacement)?

_____

Please check which activites you currently participate in or have previously participted in:

❒ Running ❒ Walking

❒ Golf ❒ Cycling

❒ Basketball ❒ Hiking

❒ Softball ❒ Other: _____

Which activited exacerbate your pain on a daily basis? *(please check all that apply)*

❒ Standing ❒ Kneeling

❒ Walking ❒ Bending/squatting

❒ Stairs *(going up)* ❒ Running (at what

❒ Stairs *(going down)* *distance?)* _____ mile(s)

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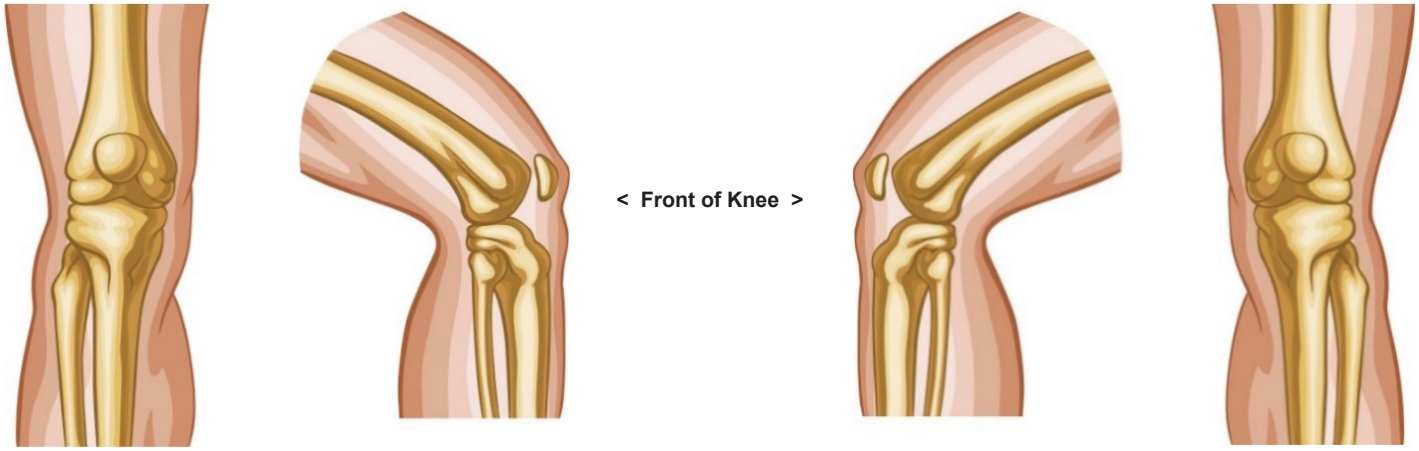
Which of the following have you <u>ever tried</u> or taken to help reduce your knee pain? *(Please check all that apply)*

- ❒ Stretching
- ❒ Home Exercise Program
- ❒ Gym/Personal Trainer
- ❒ Biking or Cycling
- ❒ Compression Sleeve
- ❒ Massage Therapy
- ❒ Meditation or Mindfulness
- ❒ Nerve Ablation
- ❒ Topical Gel
- ❒ Elliptical
- ❒ Swimming
- ❒ Wedged Shoe Inserts
- ❒ Walking Aids *(cane, walking poles)*
- ❒ Acupuncture
- ❒ Pilates
- ❒ Laser Therapy
- ❒ Ultrasound *(ECSWT)*
- ❒ Resistance Exercise: *If yes, over what time period?* _____
- ❒ Diet/Weight Loss
- ❒ Thermal Therapy *(ice or heat)*
- ❒ Hypnosis
- ❒ Kinesio Taping
- ❒ Yoga
- ❒ Counseling/Biofeedback Therapy
- ❒ Electrical Stimulation Therapy
- ❒ Magnet or Copper Bands

Please circle/notate the area(s) where you experience pain:

<u>Right Knee</u> **<u>Left Knee</u>**



Front view | Side view | Side view | Front view

Please make notes about specific areas where you experience pain: *(i.e. below knee cap, front of left leg, radiating down)*

_____

_____

_____

How would you describe your knee pain? *(Please check all that apply)*

- ❒ Grinding ❒ Right Knee ❒ Left Knee
- ❒ Sharp ❒ Right Knee ❒ Left Knee
- ❒ Aching ❒ Right Knee ❒ Left Knee
- ❒ Tender ❒ Right Knee ❒ Left Knee

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Does your knee pain limit your activity level? ❒ Never ❒ Rarely ❒ Frequently ❒ Constantly

Do you ever experience swelling in your knee(s)? ❒ Never ❒ Rarely ❒ Frequently ❒ Constantly

Do you ever experience pain/swelling in your fingers & toes? ❒ Never ❒ Rarely ❒ Frequently ❒ Constantly

Do you ever have red and itchy areas on your scalp or skin? ❒ Never ❒ Rarely ❒ Frequently ❒ Constantly

How frequently do you experience knee pain?

- ❒ Constantly
- ❒ Daily
- ❒ A few times a week
- ❒ A few times a month
- ❒ Other: _____

How long does your pain usually last?

- ❒ A few seconds
- ❒ A few minutes
- ❒ A few hours
- ❒ All day
- ❒ Right ❒ Left ❒ Both knees

What is your goal from receiving treatment at Reflex? *(ex. Walking 2 miles without pain, returning to a sport etc…)*

Please answer the following questions about your knees based upon the pain you experience.

On a scale of 0 (none) to 10 (severe), please rate the following pain levels:

Daily average pain in <u>right</u> knee	0 1 2 3 4 5 6 7 8 9 10
Worst pain during the week in <u>right</u> knee	0 1 2 3 4 5 6 7 8 9 10
Daily average pain in <u>left</u> knee	0 1 2 3 4 5 6 7 8 9 10
Worst pain during the week in <u>left</u> knee	0 1 2 3 4 5 6 7 8 9 10

Please answer the following questions while thinking of your knee pain symptoms.

On a scale of 0 (none) to 10 (severe), please rate your **<u>average</u>** pain levels:

	<u>Right Knee</u>	**<u>Left Knee</u>**
Grinding/clicking with knee movement:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
While Walking:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Going up and down stairs:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
At night in bed:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Rising from a chair:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

<u>Office Use Only</u>

Height: _____in. Weight: _____lbs. BMI: _____

BP: _____mm/Hg. Temp: _____

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Reflex Acknowledgement and Consent

I understand that **Reflex,** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my providers efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

If desired, our Reflex provider is happy to write you a 'Doctor's Note' for one day of release from work for the day of your injection. If you need additional paperwork done for Disability claims, Workers Comp, or other extended release you will need to obtain this through your primary care physician, as Reflex does not offer these services at this time.

I understand that if I need additional documentation for Disability, workers comp or other extended release I will obtain that through my primary physician.

Please see reverse side to sign →

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By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Signature:_____
Date:_____
(Patient) – or – (Patient Representative)

Patient has refused to sign this document: _____ Date _____
(Reflex Staff Member)

Please list anyone you authorize us to discuss your health and treatment with (such as a spouse or care giver).

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

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Reflex Financial Policy

Bills from Reflex will show up as "Integrated Joint Specialists", which is our legal company name.

We accept payment by check, Visa and MasterCard (no cash). We will add a $25.00 charge to your account for returned checks. Our Reflex Team will assist you if you need to set up a payment plan.

We reserve the right to send all accounts with balances over 90 days old to an outside collection agency. All accounts sent to collections may be charged a 15% processing fee. You may be responsible for all reasonable collections and attorney costs incurred.

Insurance

Please note that you, the patient, have a contract with your insurance carrier. It is the patient's responsibility to verify coverage for specialist services prior to being seen at our office. We do not guarantee that your insurance will cover our services. As a courtesy to our patients, we will bill your primary, secondary and tertiary insurance carriers based on information you provide on your patient registration forms. It is the patient's responsibility to notify the clinic of any changes in your insurance coverage. We are required by the insurance carriers to verify your coverage at the time of service. Please bring your insurance card to every visit.

Co-payments are due at the time of service. We will bill you for deductibles and co-insurance balances when we receive an Explanation of Benefits ("EOB") from your insurance. If your insurance has not paid within 30 days, we reserve the right to make it your responsibility to follow up with them.

Cancellations

Out of respect for other patients, patients arriving 10 minutes late to an appointment will be asked to reschedule. If you need to cancel or reschedule your appointment, we ask that you do so 2 business days in advance so we have time to make appropriate adjustments to the schedule. Patients who do not cancel or reschedule appointments at least 1 business day in advance (e.g. 2pm Monday appointments need to be rescheduled before 2pm on Friday) will have a $50 fee added to their patient account. Exceptions can be made for emergencies at our discretion. To ensure that we won't have to reschedule any of your appointments, feel free to come in early and enjoy a cup of tea or coffee with our concierge.

Collection Status Patients

If your account is in a collection status, we will require $100.00 at each office visit which will be applied to your account balance. We reserve the right to discharge from our practice any patients with delinquent accounts.

The "Reflex Discount Program"- Special Rates for Patients without Insurance Coverage

Reflex has developed a special discounted fee structure for patients who have no medical insurance and pay out of pocket. Our professional staff is available to assist with the process from your initial phone call or email through the final steps of your care. We will work with you along the way, to ensure that you are always aware of the costs of your treatment plan – prior to consenting to that plan.

Agreement to Financial Terms:

I agree that if my insurance carrier denies payment of claims for any reason, I will be financially responsible for any charges incurred during my care.

I have read and understand the terms of this financial policy. I agree to comply with the terms set forth in this policy for services rendered by Integrated Joint Specialists dba Reflex.

_____ _____

Patient Signature **Date**

Integrated Joint Specialists DBA Reflex
Four Lincoln Center
10250 SW Greenburg Road Ste. 115
Tigard, OR 97223

Reflex Medical Documents Release Form

State and federal laws recognize the need for written authorization.

All releases based on this form include records leading up to the signed date, as well as all records created at the office of Reflex going forward. This consent form will remain valid for three years following the signed date, unless Reflex receives written notification from the signee to revoke said status.

The purpose of this *Authorization* is to enable the individual(s)/group(s)/practice(s) named above to release, review, and coordinate information regarding my medical care received from Reflex. I understand that once my health related information is released by Reflex, they can no longer guarantee the confidentiality of my information because it is no longer under their control.

There is no fee associated with records released from Reflex.

To obtain a copy of test results, procedures and/or notes that were done at another health care organization, please contact that facility directly. Reflex is not able to request them on your behalf without your previous written consent at that facility.

By signing below, I authorize Reflex to provide medical records/health related information pertaining to my treatment as necessary.

Patient Name | Patient Signature | Date

Patient date of birth | Patient Address

If patient is less than 18 years of age:

Guardian Name | Guardian Signature | Date