Providence Medical Group
Olympia Physical Medicine
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PROVIDENCE
Medical Group

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Olympia Physical Medicine Clinic

We appreciate the opportunity to provide Physical Medicine and Rehabilitation services to you. We view you and your family as the most important members of the treatment team. Please share your treatment preferences and goals. As we proceed in treatment, please advise your doctor if you experience any unusual symptoms or changes. Feel free to ask questions about your care.

Office Hours

Our office is open Monday through Thursday 8:00 a.m. - 4:00 p.m. We are closed on Fridays, most holidays and weekends. If you have a medical emergency, please go to the Emergency Department or call 911.

Missed Appointments

We reserve your appointment time for you. We require 48 hours advance notice if you are unable to come to your scheduled clinic visit. We may not be able to reschedule you if such notification is not received. Please let us know if an unanticipated event comes up--even if it is within 48 hours. **Medication refills will not be refilled if appointments are missed without advance notification.**

Medication Management and Referral Status

On your initial visit, you will need to provide information regarding your current medications (i.e. medication, dose and frequency). While receiving treatment, if you need a prescription refill for a medication prescribed through this office, we require 72 hours (3 working days) advance notice. **Please do not wait until you run out.** For refills, you will need to contact your pharmacy and they will fax us a request.

Risks and Benefits of Treatment

As part of our philosophy of informed consent, we want you to be aware of some of the potential general risks and benefits for Physical Medicine Rehabilitation Services. We will work with you to minimize your risks and maximize your benefits.

POTENTIAL BENEFITS:

1. **Reduction of your pain** through prescribing therapy involving stretching and/or moving parts of your body, medical management of your medications and other treatments.

2. **Improvement of your ability** to perform functional activities relating to your self care, work or home (communication, swallowing, bowel or bladder, medical status, mobility, self care, home/work and community activities, etc.) through a rehabilitation therapy program.
3. **Training and education** of how to perform exercises on your own and/or with your family or caregiver to promote continued improvement in a safe manner. We will also share information on community resources and/or equipment to help you function at home and work.

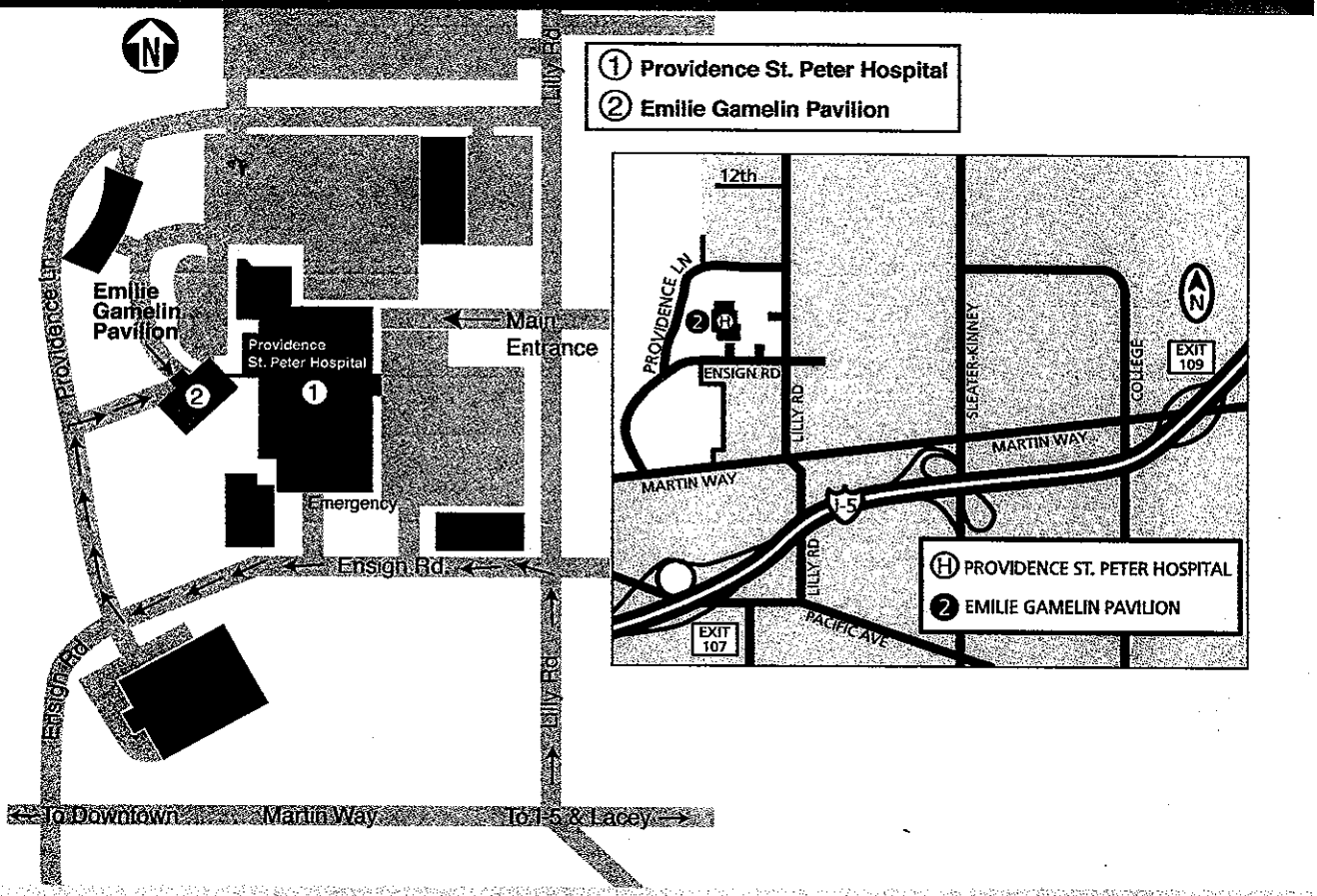
POTENTIAL RISKS

1. **Increased pain** as we assess your ability to move your body and then work to improve your movement. This is particularly true if you have not used part of your body for some time or experienced recent changes in your body/medical status.
2. There is a **risk for falls** as you work on functional activities such as walking and transferring. This risk can be due to impairment of your strength, endurance, balance or cognition.
3. If you are experiencing swallowing problems, there is a **risk for aspiration** (food or liquids in the lungs) with oral feeding and assessment. This may include testing in Diagnostic Imaging.
4. You may receive **electromyography** (EMG) which involves insertion of a needle for testing your neurological/muscle function. This will be done only by a physician with training and skills who will discuss this with you prior to any procedure.
5. Your physician may prescribe **medications, therapy, exercises, lab work or diagnostic testing** that has risks as well as benefits. Please ask for further information if you have questions or concerns about these recommendations.

Financial Information:

If you have questions regarding your insurance coverage, please contact your insurance company directly. Every plan differs in benefits. We do accept Medicare assignment. We also accept contract rates for those health plans where this has been negotiated. If you have co-payments due, please pay these when you arrive for your appointment. **Please update us immediately if your insurance changes.** We will assist in obtaining needed prior authorization for services when we are aware of the need for this. However, **you are financially responsible for the medical rehabilitation services provided to you.** In the event your health plan determines a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of your bill.

Driving Directions to Providence St. Peter Hospital Emilie Gamelin Pavilion



- **Traveling southbound I-5**, take exit 109. Turn right onto Martin Way. Turn right onto Lilly Rd. Turn left onto Ensign Rd. Turn right onto Providence Lane. The Emilie Gamelin Pavilion is the first building on the right.

- **Traveling northbound I-5**, take exit 107. Turn right onto Pacific Ave. Turn left onto Lilly Rd. Turn left onto Ensign Rd. Turn right onto Providence Lane. The Emilie Gamelin Pavilion is the first building on the right.

PATIENT HISTORY FORM

Name: _____ **DOB:** _____ **Date:** _____

Medical issue that brings you to clinic:

_____

_____

What are the three most important concerns you would like to discuss today?

1. _____
2. _____
3. _____

SYSTEM REVIEW: (Please circle yes or no):

CONSTITUTIONAL:
Yes No Weight change
Yes No Appetite change
Yes No Fever/chills/fatigue

CARDIOVASCULAR:
Yes No Chest pain/palpations/fainting

PULMONARY:
Yes No Shortness of breath/cough

GASTROINTESTIONAL:
Yes No Diarrhea
Yes No Constipation
Yes No Bowel incontinence

GENITOURINARY (URINARY):
Yes No Frequency or urgency
Yes No Retention
Yes No Incontinence

PSYCHIATRIC:
Yes No Anxiety/depression
Yes No Irritability
Yes No Mood swings
Yes No Suicidal

MUSCULOSKELETAL:
Yes No Neck/mid-back/low back pain
Yes No Muscle spasms
Yes No Joint pain

NEUROLOGIC:
Yes No Decreased memory
Yes No Trouble swallowing
Yes No Trouble walking/Falls
Yes No Loss of sensation
Yes No Weakness

SKIN:
Yes No Wound/breakdown

EYES:
Yes No Blurred/double vision
Yes No Glasses

ENT:
Yes No Difficulty hearing
Yes No Difficulty swallowing

HEMATOLOGIC:
Yes No Increased bruising/bleeding

LYMPH:
Yes No Swollen glands

Medical History: (Circle items that apply to you)

Diabetes	Arthritis	Heart disease	Brain injury
High blood pressure	Chronic pain	High cholesterol	Fibromyalgia
History cancer	MS	Kidney disease	Muscular dystrophy
Low thyroid	Spinal cord injury	Lung disease	Spine (neck or back) pain
Stroke			

All other medical history (including surgeries) PLEASE BE COMPLETE AND LIST ALL MEDICAL HISTORY:

_____

_____

_____

Social History:

Where do you live? mobile home apartment condo house assisted living
Does anyone live with you? no significant other family friends
Do you have any help or assistance in the home (such as a caregiver)?

Are you working? If yes, please list current occupation:
If no, what is the reason? retirement disability laid off
What year did you stop working?

Alcohol use: Never Rarely Moderate Daily **Tobacco use:** Never Quit Currently smoke _____ packs/daysince _____
Drug use: Never Type/Frequency _____
Any history of addiction to any substance (alcohol, drugs): Yes No

Are you currently in therapy: physical occupational speech therapy
Are you currently exercising(please list exercise routine): _____

Family History:

Does anyone in your immediate family have any problem with muscle or nerves? _____

Current Medications:

List all medications (prescription and non-prescription) that you are currently taking.

MEDICATION DOSE

_____

_____

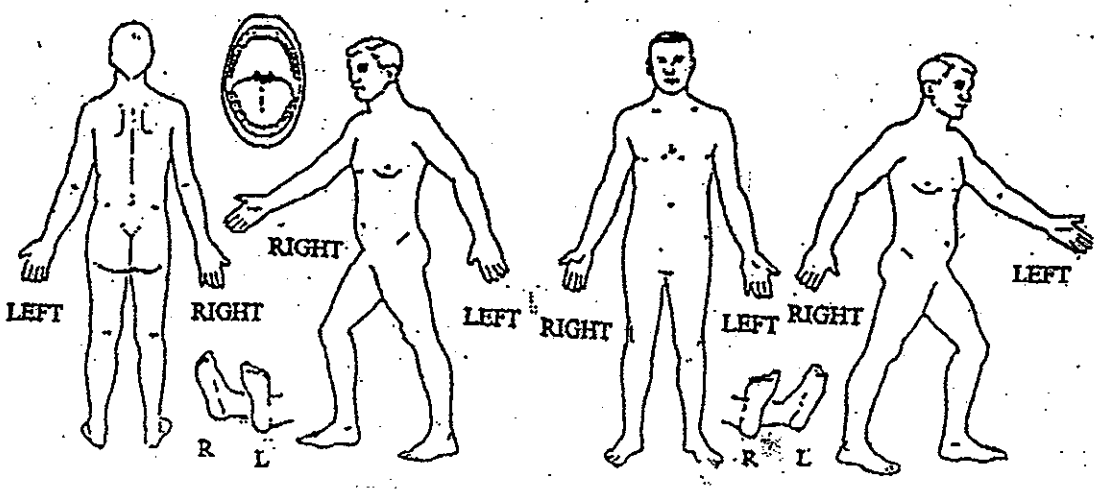
_____

_____

Are you allergic to any medications? _____ If yes, please list: _____

Other Information regarding today's visit that is important I know:

If you are having pain, please designate the area on the pain diagram below:



SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

☐ New patient ☐ Update **Account #:**

Which doctor are you seeing? ☐ NEWELL-EGGERT ☐ HECHT ☐ JOHNSON ☐ CARTER
Previous or current primary care physician? _____
Who referred you to this office? _____

BIRTH DATE: ___/___/___ (month day year)

PATIENT NAME: Last First MI

SEX: ☐ M or ☐ F

ADDRESS

Street _____ Apt / Unit / Space (circle if applicable)

City State Zip

Home Phone:

Cell phone:

Work phone:

Marital Status: Single / Married / Divorced / Widowed / Other (circle one)

Social Security #: ___-___-___

e-mail address: _____

If employed, employer name & job title: _____

Employer address: _____

EMPLOYMENT STATUS: ☐ Full-Time ☐ Part-Time

Are you RETIRED? ☐ YES or ☐ NO

Date of retirement: ___/___/___ (Month Day Year)

Do you attend school? ☐ YES or ☐ NO

If so, name of school: _____

Insurance Information

Insurance Information	Primary Insurance	Secondary Insurance
Insurance Company Name		
Subscriber Name:		
Subscriber's Employer:		
Relationship to Patient		
Subscriber ID# or SSN		
Group, Member # or Claim #		
Subscriber Birthdate & Sex: MALE or FEMALE	M or F dob:	M or F dob:
Subscriber Address (if diff. from patient)		
Subscriber Phone # (if diff. from patient)		

This section should be completed if you have a spouse or you are the dependent/child

☐ Husband or ☐ Father of Patient (If DEP or MINOR)	☐ Wife or ☐ Mother of Patient (If DEP or MINOR)
Name (Last, First, MI):	Name (Last, First, MI):
Address:	Address:
Employer:	Employer:
Phone:	Phone:
Position:	Position:
How Long:	How Long:

The above information is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made.

IF INSURANCE CARD(S) ARE NOT PROVIDED AT THE TIME OF YOUR VISIT, YOU MAY BE BILLED PRIVATELY OR YOUR APPOINTMENT MAY BE RESCHEDULED.

Signature: _____ **Date:** ___/___/___