

PATIENT INFORMATION

Patient's Legal Name _____ Social Security # _____ Sex M F
Birth Date _____ Age _____ Marital Status: Married Single Widowed Divorced Separated
Mailing Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Do we have permission to leave a message on your phone? Yes No
Text or email appointment reminders? Yes No Email: _____
Have you received home health services in the last 60 days? Yes No
List other providers you are treating with (excluding your MD): _____

SPOUSE, PARENT/LEGAL GUARDIAN & EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Birth Date _____ Sex M F
Work # _____ Cell # _____
Place of Employment _____ Occupation _____
In case of emergency, please contact: _____ Relationship _____
Home # _____ Work # _____ Cell # _____

ACCIDENT INSURANCE INFORMATION

PLEASE COMPLETE: **Work Related** Yes No **Auto Accident** Yes No **Other Accident** Yes No
Accident Insurance _____ Claim # _____
Adjuster's Name & Phone Number _____
Date of Accident _____ Describe _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____
Subscriber's Name _____ Subscriber's Name _____
Birth Date of Policy Holder _____ Birth Date of Policy Holder _____

ADDITIONAL INFORMATION

Place of Employment _____ Occupation _____
Family Physician _____ Referring Physician _____

I understand that should I default on payment of this account and collection agency services are required, all costs of collection including attorney fees will be added to the balance of said account.

Signature _____ Date _____

PLEASE PRESENT YOUR PHOTO ID & HEALTH INSURANCE CARD(S) TO OUR FRONT DESK PERSONNEL

Medical History

NAME: _____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

WHAT EASES YOUR PAIN? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

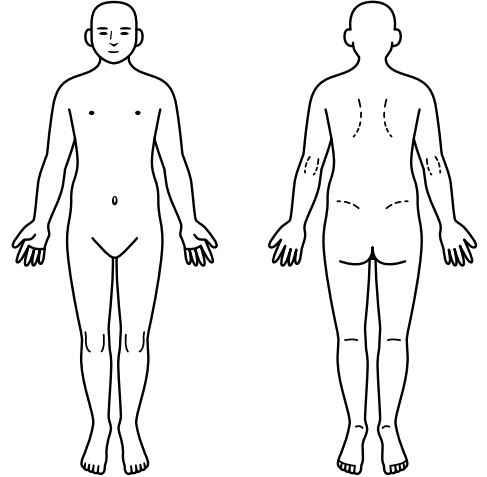
HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

PLEASE SPECIFY: PT CHIROPRACTIC OTHER _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

X-RAY CT SCAN MRI EMG

Please mark the areas of your pain here:



Please mark any of the following past and current conditions that apply to you (*be as thorough as possible*):

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Allergies			Dizzy Spells			MRSA		
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinsons		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High Cholesterol			Speech Problems		
Chemical Dependency			High/Low Blood Pressure			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year? YES NO Have you had two or more falls in the last year? YES NO

Please describe **all surgeries** or hospitalizations (*continue on back side if necessary*):

SURGERY TYPE: **DATE (mm/yyyy):**

Please list **all medications** you are currently taking (*continue on back side if necessary*):

MEDICATION	DOSAGE	FREQUENCY	ROUTE	REASON TAKING

SIGNATURE: _____

DATE: _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I understand that:

- As part of my health care, Orthopedic Rehab Inc. originates and maintains health records describing my health history, symptoms, examinations, diagnoses and treatment.
- The use and disclosure of my protected health information (PHI) by Orthopedic Rehab Inc. is necessary in order to provide my medical care, and is also necessary for Orthopedic Rehab Inc. to obtain payment for my treatment and to carry out the practice's health care operations.
- I have the option to receive a copy of **Orthopedic Rehab Inc.'s Notice of Privacy Practices** which provides a more complete description of the use and disclosure of my health information, and that I have the right to review that Notice prior to signing this consent. I also understand that Orthopedic Rehab Inc. reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab Inc. will mail me a copy of any revised Notice prior to its implementation.

I give Orthopedic Rehab Inc. permission to talk to the following person/people regarding my account and health information:

NAME:

RELATIONSHIP TO PATIENT:

CANCELLATION AND NO SHOW POLICY

Your appointments are reserved especially for you and are very important to the OrthoRehab team. We understand that sometimes schedule changes are necessary and therefore, we respectfully request at least 24 hour notice for cancellations or rescheduling of appointments. Because of the busy nature of our office, 24 hour notice allows us time to offer your appointment to another patient.

Missed scheduled appointments, without providing 24 hour advance notice, will be charged a \$25 fee.

ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab Inc. I understand that I am liable for any charges incurred should my insurance or the liable party's insurance deny payment for ANY reason.

Although Orthopedic Rehab Inc. contracts with most insurance providers, they bill my insurance as a courtesy to me. I will provide all pertinent and related insurance information, including any accident, automobile, liability, and or health insurance. Orthopedic Rehab Inc. reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charge when permitted by law. Orthopedic Rehab Inc. will not bill attorneys for any claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are. **I agree to pay any co-payments, co-insurance, and deductibles at the time of service.** I understand that should my balance exceed 90 days, a finance charge will begin to accrue.

Orthopedic Rehab Inc. will arrange a payment plan and/or assist me with Care Credit, when necessary. Unless payment arrangements are made with Orthopedic Rehab Inc., past due balances will be sent to an outside collections agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including attorneys will be added to the balance of my account.

PATIENT OR GUARANTOR SIGNATURE

DATE

Name: _____

Date: _____

We are interested in knowing whether you are having difficulty at all with the activities listed below **because of your upper limb** problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, *do you or would you* have any difficulty at all with:

	Extreme difficulty or totally unable (0 points each)	Quite a bit of difficulty (1 point each)	Moderate difficulty (2 points each)	A little bit of difficulty (3 points each)	No difficulty whatsoever (4 points each)
Any usual work, housework, or school activities					
Usual hobbies, rec or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands					
Preparing food (peel, cut)					
Driving					
Vacuuming, sweeping or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80