OrthoRehab PHYSICAL THERAPY

THERAPIST OWNED & OPERATED

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/communication? 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 – present ID to front desk personnel

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 - present ID & insurance card(s) to front desk personnel

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 _____

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 collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including legal fees, up to 45%, will be added to the balance of my account. This signed document covers my entire episode of care, which comprises all charges/visits/treatment throughout the duration of care.

Signature _____ Date _____

Policy

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 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 to provide my medical care, obtain payment for my treatment, and carry out the practice's health care operations.
- Orthopedic Rehab Inc. uses PHI to communicate with you via your phone and email for purposes as appointment reminders and review requests. This information is private and used for communicating content to you, the patient. PHI is never shared or sold for any other reason.
- I have the option to receive a copy of **Orthopedic Rehab Inc. 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 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 our 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 clinic, 24-hour notice allows us time to offer your appointment to another patient. Missed scheduled appointment, without providing 24-hour advanced 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 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 and understand I may be billed for any unmet patient responsibility.**

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 collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collection including legal fees, up to 45%, will be added to the balance of my account. This signed document covers my entire episode of care, which comprises all charges/visits/treatment throughout the duration of care.

_____ _____

PATIENT OR GUARANTOR SIGNATURE DATE

Medical History

OrthoRehab PHYSICAL THERAPY

NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT EASES YOUR PAIN? _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?

_____

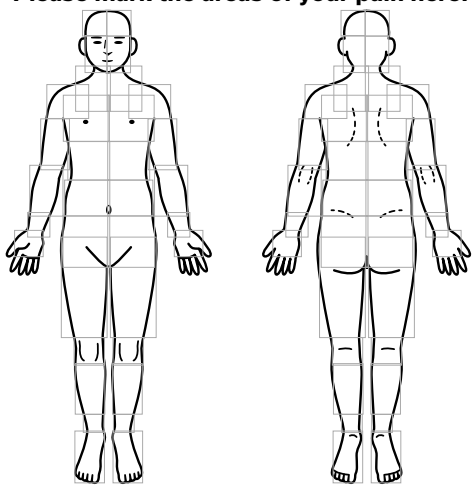
HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

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
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Autoimmune Disorder		
Cancer		
Cardiac Conditions		
Cardiac Pacemaker		
Chemical Dependency		
Circulation Problems		
Currently Pregnant		
Depression		
Diabetes		

CONDITION	YES	NO
Dizzy Spells		
Emphysema/Bronchitis		
Fibromyalgia		
Fractures		
Gallbladder Problems		
Headaches		
Hearing Impairment		
Hepatitis		
High Cholesterol		
High/Low Blood Pressure		
HIV/AIDS		
Incontinence		
Kidney Problems		
Metal Implants		

CONDITION	YES	NO
MRSA		
Multiple Sclerosis		
Muscular Disease		
Osteoporosis		
Parkinsons		
Rheumatoid Arthritis		
Seizures		
Smoking		
Speech Problems		
Strokes		
Thyroid Disease		
Tuberculosis		
Vision Problems		

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:** _____

OrthoRehab
PHYSICAL THERAPY

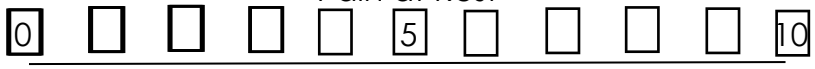
Name: _____

Date: _____

Pain Scales

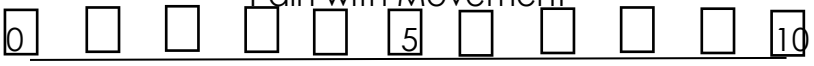
Please make a slash on the following lines to indicate your level of pain.

Pain at Rest



No Pain Worst Pain Imaginable

Pain with Movement

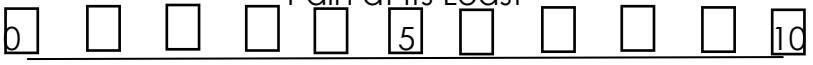


No Pain Worst Pain Imaginable

Pain at its Worst

No Pain Worst Pain Imaginable

Pain at its Least



No Pain Worst Pain Imaginable

Post-Concussion Symptom Checklist

Name: _____ Date____/_____/_____

Instructions: For each item please indicate how much the symptom has bothered you over the **past 2 days.**

Symptom	None		Mild		Moderate		Severe
Headache							
Nausea							
Vomiting							
Balance problems							
Dizziness							
Visual problems							
Fatigue							
Sensitivity to light							
Sensitivity to noise							
Numbness/tingling							
Pain other than headache							
Feeling mentally foggy							
Feeling slowed down							
Difficulty concentrating							
Difficulty remembering							
Drowsiness							
Sleeping less than usual							
Sleeping more than usual							
Trouble falling asleep							
Irritability							
Sadness							
Nervousness							
Feeling more emotional							

Exertion: Do these symptoms worsen with:

Physical Activity Yes ☐ No ☐ Not applicable ☐

Thinking/Cognitive Activity Yes ☐ No ☐ Not applicable ☐

Overall Rating: How different are you acting compared to your usual self?

Same as Usual 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Very Different ☐

Activity Level: Over the past two days, compared to what you would typically do, your level of activity has been _____ % of what it would be normally.

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