

**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 \_\_\_\_\_

# Medical History

**NAME:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**WHAT EASES YOUR PAIN?** \_\_\_\_\_

**WHAT MAKES YOUR PAIN WORSE?** \_\_\_\_\_

**WHAT ARE YOUR GOALS IN PHYSICAL THERAPY?** \_\_\_\_\_

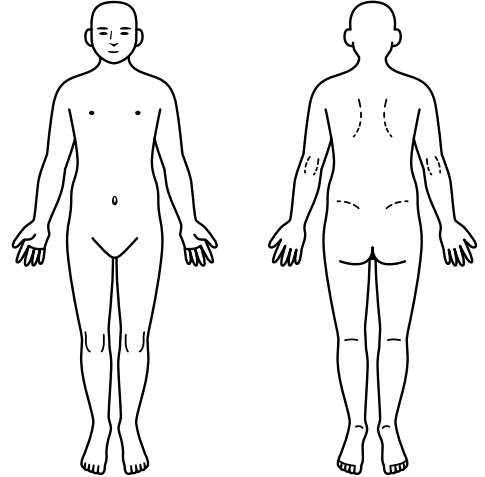
## HAVE YOU HAD PREVIOUS TREATMENT FOR THIS PROBLEM?

**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 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.**

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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 lower 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					
Getting into or out of the bath					
Walking between rooms					
Putting on your shoes or socks					
Squatting					
Lifting an object like a bag of groceries from the floor					
Performing light home activities					
Performing heavy activities around your home					
Getting into or out of a car					
Walking 2 blocks					
Walking a mile					
Going up or down 10 stairs					
Standing for 1 hour					
Sitting for 1 hour					
Running on even ground					
Running on uneven ground					
Making sharp turns while running fast					
Hopping					
Rolling over in bed					

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

SCORE: \_\_\_\_\_ / 80