

PATIENT INFORMATION

Please Print Clearly

Patient's Legal Name _____ Birth Date: _____ Age _____ Sex: M F

Mailing Address _____ City _____ State _____ Zip _____

Street Address if Different _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Marital Status: M S W D Sep

Place of Employment _____ Occupation _____

Work Address _____

Referring Physician _____ Family Physician _____

SPOUSE, PARENT, OR LEGAL GUARDIAN INFORMATION

Name _____ Relationship _____ Birth Date _____ Sex: M F

Social Security # _____ Work Phone _____ Cell Phone _____

Place of Employment _____ Occupation _____

INSURANCE INFORMATION

If Accident Related (please circle): Work Related Auto Accident Other

Date of Accident _____ Describe _____

Primary Insurance _____ Secondary Insurance _____

Subscriber's Name _____ Subscriber's Name _____

Birth Date of Policy Holder _____ Birth Date of Policy Holder _____

Policy/Claim Number _____ Policy/Claim Number _____

Group Number _____ Group Number _____

Adjuster _____

EMAIL INFORMATION

If you would like to receive appointment reminders via email, please give us your email address here:

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

Signature _____ **Date** _____

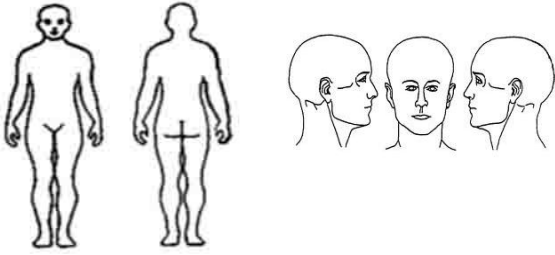
EMERGENCY INFORMATION

In case of emergency, please contact: _____

Relationship: _____ Home # _____ Work # _____ Cell # _____

Name: _____ Age: _____ Height: _____ Weight: _____

Please mark the areas of your pain here:



Using the scale, please place a mark at what level your pain is at the present time.

None _____ Severe

Have you had previous treatment for this problem?

Please specify: **PT** **Chiropractic** **Other**

Describe any other conditions or precautions:

Fall History: Injury as a result of a fall in the past year? YES NO

Two or more falls in the last year? YES NO

Surgical History Please describe any PREVIOUS surgeries or hospitalizations

Have you had any of the following tests? X-Ray: _____ CT Scan: _____ MRI: _____ EMG Studies: _____

Current Medications:

Medical History

Allergies	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Parkinsons	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Speech Problems	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No	Incontinence	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No		

Do you smoke? Yes No

Lifestyle: Sedentary: _____ Moderate _____ Heavy _____

What eases your pain? _____

What makes your pain worse? _____

What are your goals while in physical therapy? _____

ACKNOWLEDGEMENT OF RECEIPT OF ORTHOPEDIC REHAB POLICIES

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 originates and maintains health records describing my health history, symptoms, examinations, diagnoses and treatment.
- The use and disclosure of my protected health information by Orthopedic Rehab is necessary in order to provide me medical care, and also is necessary for Orthopedic Rehab 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’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 reserves the right to change the Notice and its privacy practices at any time and that if I request, Orthopedic Rehab will mail me a copy of any revised Notice prior to its implementation

I have read and understand the foregoing notice: _____

CANCELLATION AND NO SHOW POLICY

In the event that I am unable to be here for a scheduled appointment, I will call at least four hours in advance of a non-emergency cancel. **I understand that if I miss a scheduled appointment without calling that it is considered a ‘No Show’ and could be subject to a \$20.00 charge.** If I ‘No Show’ three times, I will be removed from the schedule permanently.

I have read and understand the foregoing notice: _____

ASSIGNMENT OF BENEFITS AND INSURANCE DISCLAIMER

I authorize my health insurance to make payment of medical benefits directly to Orthopedic Rehab. If covered by an insurance company that requires pre-authorization prior to service, it is my responsibility to obtain pre-authorization. **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 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 insurance, automobile insurance, liability insurance, and health insurance. Orthopedic Rehab reserves the right to lien patient recoveries from legal or insurance settlements for unpaid charges when permitted by law. As of March 1, 2010, Orthopedic Rehab will no longer bill attorneys for any claims.

I am responsible for knowing what my medical and outpatient physical therapy benefits are, including deductibles, co-insurance amounts, co-pays, visit or dollar limits, medical necessity, and pre-authorization requirements. I agree to pay any co-payments, co-insurance, and deductible at the time of service. **I understand that should my balance due exceed 90 days, a finance charge will begin to accrue.**

Orthopedic Rehab will work with me to collect unpaid balances, arranging a payment plan if necessary. Unless a payment plan is arranged with Orthopedic Rehab, past-due balances will be sent to an outside collections agency. Once sent to outside collections, past due amounts must be paid in full before I will be seen again for any occurrence of physical therapy. Future visits will be on a cash-only basis. **I understand that should I default on payment of my account and collection agency services are required, all costs of collection including any attorney fees will be added to the balance of my account.**

I have read and understand the foregoing notice: _____

X

Patient or Guarantor Signature

Date