Patient Information Form

Patient Information

Last Name/Suffix:	First Name:	Middle Initial:	
Street Address (no P.O. Box):	City:	State:	Zip Code:
Mailing Address (if different):	City:	State:	Zip Code:
Home Phone: (☐ Preferred Contact #)	Cell Phone: (☐ Preferred Contact #)	Email Address:	
How would you like to receive appointment reminders? ☐ Email ☐ Text Message	Status: ☐ Single ☐ Married		
Date of Birth:	Age:	Sex: ☐ Male ☐ Female	Preferred Pronouns:	SSN:

Employment Information

Employer Name:	Employment Status: ☐ None ☐ Full Time ☐ Part Time		
Address:	City:	State:	Zip Code:
Work Phone Number:	Occupation:		

Physician Information

Name of Referring Physician:	Phone #:	Follow up MD Appointment:
Name of Primary Care Physician:	Phone #:	Follow up MD Appointment:

Personal Insurance Information

Are you the Policy Holder? ☐ Yes / ☐ No	Name of Policy Holder:		
Policy Holder Relationship to the Patient:	Sex: ☐ Male ☐ Female		
Subscriber's Address (if different):	City:	State:	Zip Code:

Primary Insurance		**Secondary Insurance**	
Insurance Company/Plan:		Insurance Company/Plan:	
ID:	Group #:	ID:	Group #:

Worker's Compensation/Automobile Accident Information

Worker's Compensation Injury? ☐ Yes / ☐ No	Do you have a Lawyer? ☐ Yes / ☐ No
Auto Accident Injury? ☐ Yes / ☐ No	Date of Accident:

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Emergency Contact Information

Contact Name:	Phone #:	Relationship to Patient:

Acknowledgement of Notice of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand that OSMS may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, and any related healthcare operations.

Patient Signature:	Patient or Parent/Guardian's Signature
Date of Birth:	Date:

Additional Questions

Have you had any therapy (PT/OT) this year? ☐ Yes ☐ No Are you receiving Home Health Services? ☐ Yes ☐ No	Have you ever been here before? ☐ Yes / ☐ No Have you had physical therapy elsewhere? ☐ Yes / ☐ No

How did you hear about us? ☐ Google ☐ Yahoo ☐ Primary Care Doctor ☐ Orthopedic Doctor ☐ Neurologist ☐ Facebook ☐ Yellow Pages ☐ Website ☐ Previous Patient ☐ Other: ______________________________

Are you currently taking medication? ☐ Yes/ ☐ No If Yes, Please provide a list including dosage and frequency below:

____

____

____

____

____

____

Missed Appointment/No-Show Policy

1. **1st Miss/No-Show: We will review our Missed Appointment/No-Show Policy.**
2. **2nd Miss/No-Show: There will a $25 charge.**
3. **3rd Miss or more: Patient will be discharged.**

Patient Signature:	Date:

Medical History Form

What is your injury/reason for coming for physical therapy? ______________________________________

Date of Injury? ____________ How did the injury occur? _______________________________________

Have you received treatment for this condition before? ☐Yes ☐No If Yes, date: ________________

Have you had surgery for this condition? ☐Yes ☐No If Yes, date: ________________

What is your goal of therapy? ____

Are you Pregnant? ☐Yes ☐No

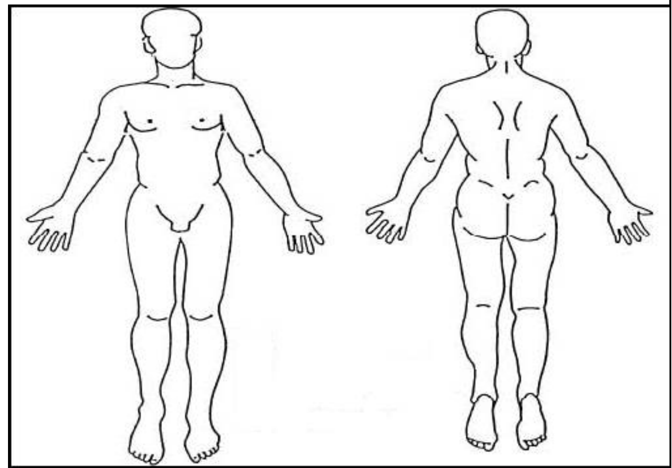
Have you ever, or are you presently being treated for any of the following conditions?

Condition	Yes	No
Allergies	☐Yes	☐No
Arthritis	☐Yes	☐No
Asthma/Hay Fever	☐Yes	☐No
Cancer	☐Yes	☐No
Circulation Problems/Vascular Disease	☐Yes	☐No
Currently Pregnant	☐Yes	☐No
Depression/Anxiety	☐Yes	☐No
Diabetes	☐Yes	☐No
Epilepsy/Fainting	☐Yes	☐No
Fibromyalgia	☐Yes	☐No
Headaches	☐Yes	☐No
Hearing/Vision Impairment	☐Yes	☐No
Heart Disease/Heart Attack	☐Yes	☐No
Hepatitis	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
HIV/AIDS	☐Yes	☐No
Kidney Disease	☐Yes	☐No
Neurological Disease (MS, Parkinson's)	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Pacemaker	☐Yes	☐No
Respiratory Problems	☐Yes	☐No
Seizures	☐Yes	☐No
Stroke	☐Yes	☐No
Thyroid Problems	☐Yes	☐No
Sprain/Strain/Dislocation/Fracture		
Neck/Head (including concussion)	☐Yes	☐No
Trunk (ribs, vertebrae, sternum)	☐Yes	☐No
Upper Extremity (shoulder/clavicle/elbow/wrist)	☐Yes	☐No
Lower Extremity (hip/knee/ankle/foot)	☐Yes	☐No
Surgical History		
List w/ dates:		

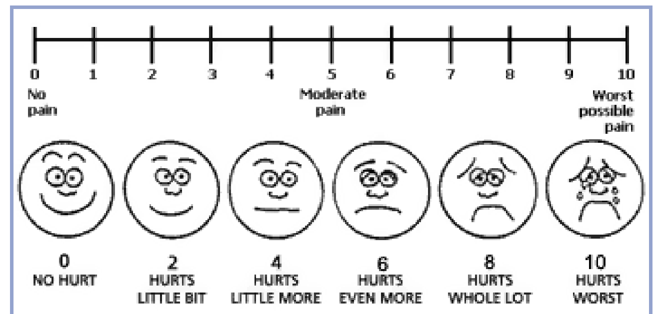
Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

KEY

Symbol	Meaning	Symbol	Meaning
↑o↓	Radiating Pain	***///////***	Numbness/Tingling
0000	Ache/Pain	**XXX**	Spasms
ZZZ	Tenderness		



Using the scale below please rate your pain at its best _____ and at its worst _____.



Please inform us of any changes in the above information immediately

Patient or Parent/Guardian's Signature____ **Date:** _______________

ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC.

Financial Agreement

Patient Name: ___________________________________ Birth date: _______________

In consideration of the treatment of the above-named patient, I AGREE TO PAY ALL CHARGES INCURRED, OR ANY UNPAID BALANCE REMAINING AFTER INSURANCE, for the physical therapy services at the usual rates of Orthopaedic and Sports Medicine Specialists (OSMS).

- **Patients Using Health Insurance**

I have informed OSMS of certain insurance policies, which I believe, will provide coverage for all or at least part of the services rendered. However, I am not seeking treatment at OSMS for the above-named patient based on any representations by OSMS that such an insurance policy provides coverage. I understand that I will be personally liable for all expenses incurred if no coverage is available.

- **Patients Using Auto or Worker's Compensation Insurance**

OSMS will bill your auto or workers' comp insurance first. Your health insurance will be billed in the event that your worker's compensation claim is denied or your auto personal injury benefits are exhausted.

In those cases where there is a default in the obligations of this agreement, it is understood that the person indebted will be liable for all costs of collection, including reasonable attorney's fees.

Authorization to Pay Insurance Benefits

I hereby authorize payment directly to OSMS of benefits otherwise payable to me but not to exceed OSMS usual charges. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION. I further agree and acknowledge that my signature on this document authorizes OSMS to submit claims for services rendered without obtaining my signature on each claim to be submitted and that this signature will bind me as though I had personally signed the particular claim. I agree that any insurance checks belong to OSMS for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me.

____ ________________

Signature of Patient or Legal Guardian *Date*

____ ________________

Printed Name of Patient or Responsible Party *Date*

ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC.
NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Orthopaedic and Sports Medicine Specialists' Legal Duty

Orthopaedic and Sports Medicine Specialists, Inc. (OSMS) is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

OSMS uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, OSMS may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

OSMS may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, OSMS's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

OSMS may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. OSMS will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that OSMS may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on OSMS's health information practices or if you have a complaint, please contact the following person:

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