



Patient Information Form

<u>Patient Information</u>				
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: (<input type="checkbox"/> Preferred Contact #)		Cell Phone: (<input type="checkbox"/> Preferred Contact #)		Email Address:
How would you like to receive appointment reminders? <input type="checkbox"/> Email <input type="checkbox"/> Text Message			Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:	
<u>Employment Information</u>				
Employer Name:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Address:		City:	State:	Zip Code:
Work Phone Number:		Occupation:		
<u>Physician Information</u>				
Name of Referring Physician:		Phone #:	Follow up MD Appointment:	
Name of Primary Care Physician:		Phone #:	Follow up MD Appointment:	
<u>Personal Insurance Information</u>				
Are you the Policy Holder? <input type="checkbox"/> Yes / <input type="checkbox"/> No		Name of Policy Holder:		
Policy Holder Relationship to the Patient:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Subscriber's Address (if different):		City:	State:	Zip Code:
Primary Insurance		Secondary Insurance		
Insurance Company/Plan:		Insurance Company/Plan:		
ID:	Group #:	ID:	Group #:	
<u>Worker's Compensation/Automobile Accident Information</u>				
Worker's Compensation Injury? <input type="checkbox"/> Yes / <input type="checkbox"/> No		Do you have a Lawyer? <input type="checkbox"/> Yes / <input type="checkbox"/> No		
Auto Accident Injury? <input type="checkbox"/> Yes / <input type="checkbox"/> 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:
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you receiving Home Health Services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been here before? <input type="checkbox"/> Yes / <input type="checkbox"/> No Have you had physical therapy elsewhere? <input type="checkbox"/> Yes / <input type="checkbox"/> No
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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. **Missed Evaluation. There is a \$70.00 fee.**
2. **1st Missed Follow up appointment: Missed Appointment/No-Show Policy will be reviewed.**
3. **2nd Missed Follow up appointment: There is a \$25 fee.**
4. **3rd Miss or more: Patient will be taken off the schedule.**

Patient Signature:	Date:
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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?

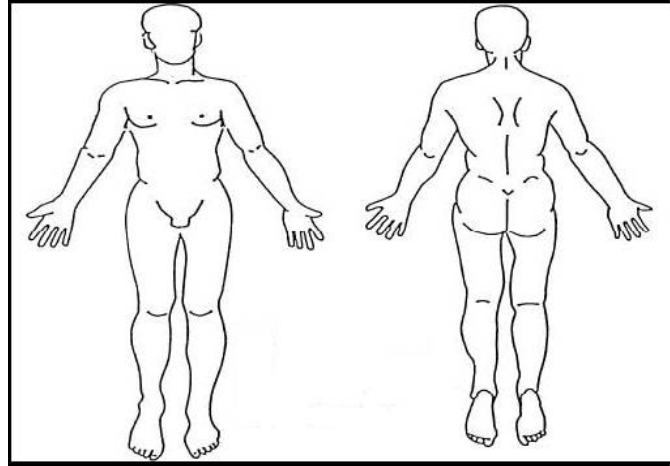
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems/Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing/Vision Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease/Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Disease (MS, Parkinson's)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Sprain/Strain/Dislocation/Fracture	
Neck/Head (including concussion)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trunk (ribs, vertebrae, sternum)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Upper Extremity (shoulder/clavicle/elbow/wrist)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lower Extremity (hip/knee/ankle/foot)	<input type="checkbox"/> Yes <input type="checkbox"/> No

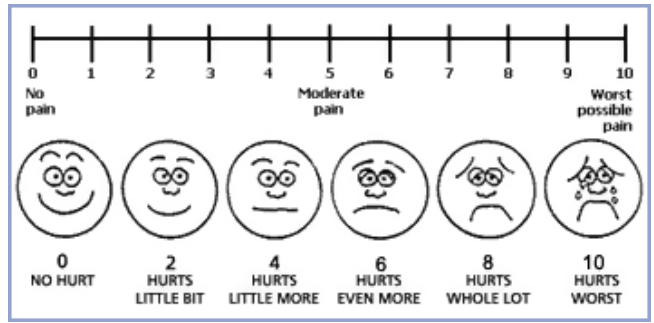
Surgical History	
List w/ dates:	

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
 ↑↓ 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.

There will be a \$70.00 charge for evaluations missed without prior notification and \$25.00 for follow up appointments. We have a 24-hour answering service available to take your cancellation message. Any patient who misses more than two visits in a row without contacting our office in a timely fashion will be taken off the schedule.

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.

Signature of Patient or Legal Guardian

Date

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 you 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:

Orthopaedic and Sports Medicine Specialists, Inc.
Timothy N. Moulton, Office Manager
231 Sutton Street Suite 1C; North Andover, MA 01845
Tel: 978-685-8059 | Fax: 978-685-6421