Orthopedic
Rehabilitation
Specialists

Have you had any type of therapy (OT, PT, Speech or Chiropratic) during 20__ *other than* in our office.

☐ **YES *if so*:**

When_____

Where_____

How Many Visits_____

☐ **NO**

Patient Name:_____

Date:_____

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Date_____

Patient Name_____ Date of Birth_____

Address_____Zipcode_____

Home Phone # _____Cell Phone #_____ Marital Status_____

S.S.# _____-_____-_____ Driver's License #_____

E-mail Address_____ Referred by: _____

Employer_____ Office Phone#_____

Employer Address_____Occupation_____

Spouse/Responsible Party_____ Phone #_____

Employer_____ Occupation_____

Primary Insurance_____ID#_____Grp#_____

Secondary Insurance_____ID#_____Grp#_____

Is this a worker's compensation injury? ☐ **YES/** ☐ **NO** *If yes*, date of injury_____

Employer at time of injury_____ Phone #_____

Worker's comp. Insurance Carrier_____ Claim #_____

Is this an auto accident? ☐ **YES/** ☐ **NO** *If yes*, date of accident_____

Insured's name_____ Policy #_____

Auto Insurance Carrier_____ Phone #_____

Is this a liability or legal case? ☐ **YES/** ☐ **NO** *If yes*, please provide attorney information: _____

Emergency Contact_____ Phone #_____

Relationship_____ Address_____

The following persons are allowed to receive and/or review all my medical records, reports and appointments associated with my treatment. Those who *I authorize* are:

1._____ 2._____ 3._____

I authorize any insurance carrier, employer, hospital or physician to release any information requested with regard to my current physical condition. This authorization shall remain in effect until my course of treatment is completed or it is revoked by me in writing. A photocopy of this is to be considered as valid as the original.

PATIENT SIGNATURE / RESPONSIBLE PARTY

Patient/ Guardian Signature:_____ Relationship to Patient_____

Print Patient Name:_____ Date: _____

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NAME: _____ **TODAY'S DATE**: _____

DATE OF BIRTH: ____/____/____ HEIGHT _____ WEIGHT _____ ☐ **L** – HANDED – **R** ☐

Marital Status: _____ # Children _____ Ages _____ Currently Working ☐ Y ☐ N

Occupation _____ Referring MD _____

Is your present problem related to: Illness ☐ Accident ☐ Work-Related ☐

Please indicate for which body region(s) are you seeking treatment: (Please Circle)

☐ *Neck* ☐ *Mid Back* ☐ *Low Back* ☐ *Shoulder* ☐ *Elbow* ☐ *Hand* ☐ *Wrist* ☐ *Hip*
☐ *Knee* ☐ *Ankle/foot* *Other*_____

When did your symptoms start? _____

Can you identify a cause for your symptoms? ☐ **Y** ☐ **N**

If yes, specify _____

Have you ever had similar symptoms in the past? ☐ **Y** ☐ **N**

If yes, when? _____

Have you recently had the following tests? (Circle all that apply):

☐ X-Rays ☐ *CT Scan* ☐ MRI ☐ *Bone Scan* ☐ Blood Tests ☐ *EKG* ☐ Echocardiogram

☐ Stress Test ☐ *EMG* ☐ Pulmonary Function Test ☐ *Myelogram*

Pain rating: **Indicate your average level of pain by CIRCLING the appropriate number on the scale below:**

☐**0** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10**

Pain Free **Most Severe**

Have you seen anyone else for this problem? (Circle all that apply)

☐ Physician ☐ *Physical Therapist* ☐ Chiropractor ☐ *Osteopath* ☐ Podiatrist

☐ *Dentist* ☐ Psychologist/Psychiatrist ☐ *Other*

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NAME: _____

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Describe the character of your **pain**: (Does it feel... sharp, dull, achy, etc.?) _____
Is your pain worse in the **am** _____ **pm** _____?
Is the pain there all the time? ☐ **Y** ☐ **N**
Do you have numbness, tingling, or weakness? ☐ **Y** ☐ **N** Location? _____
Have you had any recent changes in your bowel, bladder or sexual function? ☐ **Y** ☐ **N**
What activities/positions make your pain **worse**? _____
What activities/positions make your pain **better**? _____

HAVE YOU:			**IF YES, EXPLAIN:**
Experienced any trauma (i.e. motor vehicle accident or fall from a height?	☐ **YES**	☐ **NO**	_____
Experienced any head trauma / brain injury?	☐ **YES**	☐ **NO**	_____
Experienced an inability to focus or concentrate recently?	☐ **YES**	☐ **NO**	_____
Experienced unusual clumsiness or lack of coordination?	☐ **YES**	☐ **NO**	_____
Had open wounds / redness / cuts / infection recently?	☐ **YES**	☐ **NO**	_____
Experienced unexplained back or flank pain?	☐ **YES**	☐ **NO**	_____
Experienced groin/hip/thigh aching or pain that increases with activity?	☐ **YES**	☐ **NO**	_____
Sustained a blow or trauma to any body part?	☐ **YES**	☐ **NO**	_____
Recently begun an exercise program or modified an existing program?	☐ **YES**	☐ **NO**	_____
Taken a long car ride / bus trip /plane ride?	☐ **YES**	☐ **NO**	_____

PLEASE PROVIDE A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	**Dosage**	**Frequency**	**How Taken (oral, injection, etc.)**

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NAME_____

Have you ever suffered from or been told that you have:	**YES**	**NO**	**Therapist Comments:**
High blood pressure	☐	☐	
Thyroid problems	☐	☐	
Diabetes (high blood sugar)	☐	☐	
Osteoporosis	☐	☐	
Circulation or vascular problems	☐	☐	
Seizures / Epilepsy	☐	☐	
Recent / Repeated Infections	☐	☐	
Arthritis / Rheumatoid Arthritis / Gout	☐	☐	
Kidney problems	☐	☐	
Cancer	☐	☐	
Head injury / Headaches	☐	☐	
Heart problems / Pacemaker	☐	☐	
Lung / Respiratory problems / Asthma	☐	☐	
Multiple Sclerosis / Parkinson's Disease	☐	☐	
Stroke / Neurological problems	☐	☐	
Liver Problems / Hepatitis	☐	☐	
Blood disorders / Blood Clots	☐	☐	
Low blood sugar	☐	☐	
Tuberculosis	☐	☐	
Broken bones (fractures)	☐	☐	
Ulcers / stomach problems	☐	☐	
Allergies	☐	☐	
FOR WOMEN ONLY:			
Pelvic inflammatory disease	☐	☐	
Endometriosis	☐	☐	
Any complicated pregnancies or deliveries	☐	☐	
Trouble with your period	☐	☐	
Are you or could you be pregnant?	☐	☐	
FOR MEN ONLY:			
Prostate Disease	☐	☐	
HAVE YOU RECENTLY HAD:			
Unexplained Weight Loss/ Gain	☐	☐	
Fatigue / Tiredness / Malaise	☐	☐	
Diarrhea / Constipation / Incontinence	☐	☐	
Frequent Urination	☐	☐	
Blood in Stool or Urine	☐	☐	
Unexplained fever or chills / sweating	☐	☐	
Shortness of breath / Difficulty Breathing	☐	☐	
Cough / Hoarseness	☐	☐	

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HAVE YOU RECENTLY HAD:	YES	NO	Therapist Comments:
Unexplained fever or chills	☐	☐	
Visual problems / Loss of Vision	☐	☐	
Joint Pain and/or Swelling	☐	☐	
Difficulty Walking	☐	☐	
Nausea / Vomiting	☐	☐	
Numbness or tingling	☐	☐	
Weakness in your arms or legs	☐	☐	
Difficulty swallowing	☐	☐	
Pain at rest	☐	☐	
Pain at night	☐	☐	
New Onset of Headaches	☐	☐	
Hearing Problems	☐	☐	
Loss of appetite	☐	☐	
Chest Pain	☐	☐	
Heart palpitations / Heart Racing	☐	☐	
Dizziness or Loss of Consciousness	☐	☐	
Loss of balance / Any Recent Falls	☐	☐	
Implants / Metal Implants	☐	☐	
Difficulty Sleeping	☐	☐	
DO YOU:			
Smoke?	☐	☐	
If yes, how much? (packs per day)	☐	☐	
Have any significant family history of illness/ disease?	☐	☐	
Have any other medical problems?	☐	☐	

HAVE YOU:			
Had surgery or been hospitalized in the past?	☐ YES	☐ NO	If yes, please explain below
A.	REASON:		DATE:
B.	REASON:		DATE:
C.	REASON:		DATE:
Who is your primary doctor, or the doctor you see most often?			
When was your last general check-up?			DATE:

Please describe your job/social activities and your current ability to perform them:

_____

What do you want to accomplish from your course of Physical Therapy Treatment?

_____

Is there anything else you feel is important to tell me?

_____

Name: _____ **Signature:** _____

Orthopedic Rehabilitation Specialists

FINANCIAL AGREEMENT

I hereby assign all medical benefits, including major medical benefits, to which I am entitled including Medicare, private insurance and any other health plans or insurance coverage to Orthopedic Rehabilitation Specialists, Inc., including any settlements from lawsuit. Please remember that verification of insurance benefits is not a guarantee of payment. I am responsible for the remaining balance, including deductibles, and non-covered expenses. If for any reason the account is assigned to an attorney for collections and/or lawsuit, Orthopedic Rehabilitation Specialists Inc. will be entitled to reasonable attorney's fees and cost of collections. To the extent necessary to determine liability of our payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical/financial record. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I authorize Orthopedic Rehabilitation Specialists Inc. to release all information necessary to secure payment.

CANCELLATION POLICY

I understand that it is my responsibility to keep scheduled appointments. **Failure to cancel with 24 hours notice will result in a $40.00 administration fee**. Failure to notify our office may result in a full day visit charge.

CONSENT, USE, DISCLOSURE AND ACKNOWLEDGEMENT OF HEALTHCARE AND PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Consent form and the posted Notice of Privacy Practices. Understand that by signing this form I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At Orthopedic Rehabilitation Specialists, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

The physical responses to a specific treatment can vary widely from person to person. It is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis(es), symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risk(s) associated with your exercise(s), your therapist will be glad to answer them.

I acknowledge and understand the statement above. I understand that my treatment program will be explained to me by Orthopedic Rehabilitation Specialists, and that I am able to ask any question or state any concerns. I understand the risks associated with a program of Physical Therapy as outlined to me, and I authorize treatment.

Patient Name (Printed):_____ Date:_____

Patient Signature:_____ Guardian (if under 18)_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.