OSSPT
ORTHOPEDIC SPINE & SPORTS
PHYSICAL THERAPY

PATIENT INFORMATION

First Name: _____ Middle: _____ Last: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SSN: _____

Home Phone: (___)_____ Cell Phone: (___)_____ **(used only to adjust appointments)**

Email: _____

Employer: _____ Work Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone: (___)_____

Who recommended us? (i.e. doctor, family, friend, previous patient, advertisement): _____

IS YOUR INJURY DUE TO A WORK INJURY OR MVA? ☐ Yes ☐ No

INSURANCE INFORMATION

Insurance Company Name: _____

Policy Holder Name: _____ DOB: ____/____/_____ SSN: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Does the patient have additional Insurance Coverage? ☐ Yes ☐ No

Secondary Insurance Company Name: _____

Secondary Policy Holder Name: _____ DOB: ____/____/_____ SSN: _____

Secondary Policy Number: _____ Group Number: _____

Is this case currently involved in litigation? ☐ Yes ☐ No

Is there an Attorney involved? ☐Yes ☐ No

If yes, Attorney Name: _____ Phone: _____

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PATIENT'S AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I, _____, authorize **Orthopedic Spine & Sports Physical Therapy** to release medical information on my behalf to the following:

Referring Physician's Name: _____

Your Insurance Company: _____

Other Physician/Other Insurance: _____

FINANCIAL AGREEMENT

I understand and agree that I am fully responsible and liable for payment of all charges assessed for physical therapy services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, I will immediately deliver such payment directly to Orthopedic Spine & Sports Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance. Should the need arise to pursue collection of outstanding payment for services rendered, I agree that all costs incurred by Orthopedic Spine & Sports Physical Therapy to collect will be added to the total balance owed. ***Please initial*** _____**.**

I hereby give authorization for payment of insurance benefits to be made directly to Orthopedic Spine & Sports Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original. ***Please initial*** _____**.**

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I agree to be on time for my appointments so that I may be given the full benefit of your scheduled treatment. Late arrival of 15 minutes or greater may result in a shortened treatment or cancellation. I am required to provide advance notice of 24 hours of cancellation. If I fail to show for an appointment or cancel without sufficient notice, I may be subject to a $25.00 charge. ***Please initial*** _____**.**

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Orthopedic Spine & Sports Physical Therapy. I realize that I am an integral part of the rehabilitation process and will be sufficiently educated about treatment and alternatives before they are performed. ***Please initial*** _____**.**

_____ Date _____/_____/_____

Signature ***(Parent or guardian signature if patient is a minor)***

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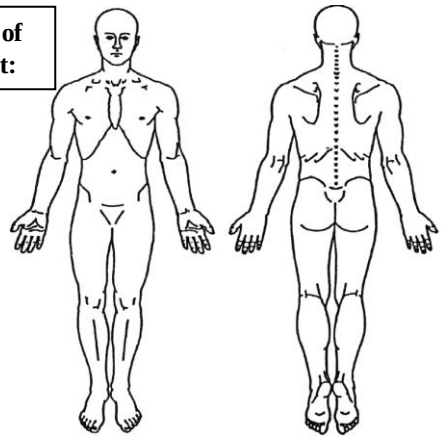
Have you <u>ever had</u> any of the following?

	Yes	No
High Blood Pressure	☐	☐
Cardiac Conditions	☐	☐
Metal Implants	☐	☐
Nervous Disorders	☐	☐
Pacemaker	☐	☐
Seizures	☐	☐
Dizzy Spells	☐	☐
Diabetes	☐	☐
Allergies	☐	☐
Fractures	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Vision Problems	☐	☐
Are you pregnant?	☐	☐
Cancer	☐	☐
Circulation Problems	☐	☐

Please indicate location of symptoms on body chart:



XXX	Sharp localized pain
////	burning
OOO	Numbness and tingling
⟶	Shooting pain

Any other illnesses or diagnoses not listed above:_____

_____

List **<u>all</u>** surgeries (including year): _____

_____

Please list **<u>all</u>** current medications (including dosages):_____

_____

Have you had any treatment for your current condition (PT, chiropractor, massage therapy, injections, etc.)? Please describe:

_____

Have you had any medical imaging performed for your current condition (x-rays, MRI's, etc): ☐ Yes ☐ No

Please describe **when and how** your injury occurred: _____

_____

What movements/positions make your symptoms **<u>worse</u>**? List any current limitations? (Please be detailed):

_____

_____

What movements/positions your symptoms **<u>better</u>?** What can you do to help reduce your pain?

_____

_____

<u>Using the pain rating scale to the right</u>:

Pain at **<u>worst</u>** pain (0-10): /10

Pain at **<u>current</u>** (0-10): /10

Pain at **<u>best</u>** (0-10): /10

<u>Pain Rating Scale</u>
0 = no pain
2-4 = mild pain
5-7 = moderate pain
8-9 = severe pain
10 = worst imaginable (requires 911 call)