ORTHOPEDIC & SPINE PHYSICAL THERAPY NEW PATIENT FORM

PRINT CLEARLY

Name (First)_____ (Last)_____ (MI)_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Social Security_____ Birth Date_____ Age_____ Sex: M / F
Email Address _____ Marital Status: M S D W

Employer_____ Address_____ Phone_____
Full Time / Part Time / Not working / Retired / Student
Emergency Contact_____ Telephone_____
Referring Physician _____ Primary Physician_____
Who may we thank for your referral? _____

Injury Type: ☐ Work ☐ Auto ☐ Home ☐ Other_____ Injury Date_____

Primary Insurance _____ ID#_____ Group #_____
Insured Name_____ SS#_____ DOB_____
Insured Employer_____ Address_____
Secondary Insurance _____ID#_____ Group #_____
Insured Name_____ SS#_____ DOB _____

Please Read and Sign:

I request that payment of authorized benefits be made to Orthopedic & Spine Physical Therapy, PC for any services furnished to me by the clinician. I authorize my holder of medical information needed to determine the benefits payable for related services about me be released to my insurance company and its agents. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

I am aware that payments for self-pays/co-pays are due at the time services are rendered. I may also be responsible for any balances/co-insurance due after insurance payment is made.

Signature:_____ Date:_____

I am aware that if I no show an appointment or do not call 24 hours ahead of my scheduled appointment I will be charged a $10.00 FEE. If I miss three appointments reserved for me without calling to cancel I forfeit the rest of my scheduled appointments.

Signature: _____ Date:_____

Orthopedic & Spine PT Medical Screening Form

Date: _____ **Name(First)**_____**(Last)**_____ **(MI)**_____

Social Security #: __ __ __ - __ __ - __ __ __ __ **Birth Date**_____ **Age**_____ **Sex: M / F**

Smoker: Y N **Pregnant**: Y N **Occupation**: Full Time / Part Time / Retired / Student

Postures / Stresses _____**Leisure / Hobbies**_____

Exercise Routine_____ **Pacemaker** Y / N

X-ray, MRI, or other imaging study? Y / N **What Body Part(s)**_____

Medications: Nil / NSAIDS / Analgesics / Steroids / Anticoagulants / Injections / Other_____

_____

Recent/major surgery: Y / N _____**Accidents:** Y / N _____

Past Medical History: Please circle each condition that you have been told you have (or had).

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually Transmitted Disease	
Blood clots	Bone or Joint infection		Asthma/Lung Disease	

Are you allergic to latex? YES NO Other Allergies:_____

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? (Circle one) Yes Yes, but not today No

Currently I am experiencing (circle all that apply):

Fever/chills/sweats	Poor balance (falls)		
Unexplained weight loss	Numbness or Tingling	Changes in appetite	Difficulty swallowing
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel or bladder function		Nausea /Vomiting	Increased pain at night

CURRENT SYMPTOMS

Present symptoms _____ **Present Since**: _____

How did it start? Gradual / sudden / Injury **Is it**? Improving / unchanging / worsening

Constant symptoms:_____ Intermittent symptoms:_____

Previous Episodes? 0 1-5 6-10 11+ Disturbed Sleep? Y / N Previous Treatments/Response to treatments_____

Worse with? Bending / sitting / lying / turning/twisting **Better with**? Bending / sitting / lying / twisting

Worse? am / as the day progresses / pm **Better?** am / as the day progresses / pm

Do you feel better when you are: Still / On the Move? **Sleeping Postures**: belly / back / side R / L

Do you have pain with: coughing / sneezing / straining ?

TURN OVER

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

Below for the Therapist:

1)_____ Rating:_____

2)_____ Rating:_____

3)_____ Rating:_____

AVG:_____

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Best for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Please label on the body charts where your symptoms are and the type of symptom by using the key below.

Indicate if those symptoms are constant or intermittent.

Ache – ////////////// A

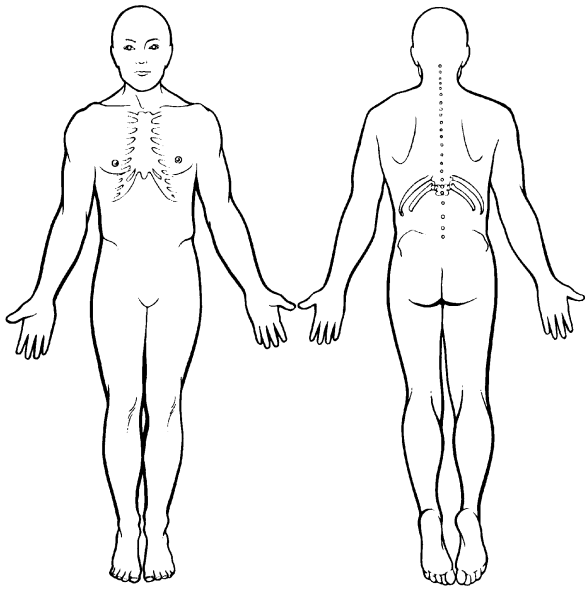
Burning – xxxxxxxx B

Pins and Needles - ^^^^^^ P

Sharp – ZZZZZ - SH

Shooting - >>>>>>> - S

Numbness – lllllll -N



CONSENT: I understand that my diagnosis & treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered._____(Sign)

CONSENT TO TREAT AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. **Patient Consent to Treat:**

   I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated and which are deemed necessary or advisable by the provider in the course of treatment.

2. **Patient Consent for Use and Disclosure of Protected Health Information ("PHI"):**

   I, the undersigned patient, give my consent to Orthopedic & Spine PT to use or disclose my protected health information ("PHI") to carry out treatment, payment or health care operations. Orthopedic & Spine PT can release, use or disclose my PHI to other health care personnel including, but not limited to, physicians, nurse practitioners, physician assistants, physical therapists, X-ray personnel, students in each of the above disciplines and other such entities or persons as are deemed related to treatment, payment and health care operations, as determined in the sole discretion of the provider, his/her practice group and their respective agents.

3. **Permission to Release Medical Record to Providers:**

   If another provider who is involved with treatment, payment or health care operations relating to me requests my medical records I consent to the release of my entire medical record maintained by the provider to those other providers.

4. **Permission to Release Billing Information over the telephone:**

   I agree, as part of this consent for payment operations, that Orthopedic & Spine PT can disclose billing information to any identity of the calling person and the calling person provides my correct social security number or health plan number.

5. **Permission to Call and Leave Voice Mail Messages:**

   I agree that Orthopedic & Spine PT may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

6. **Permission to Discuss Protected Health Information with third persons:**

   I agree that the provider may discuss my PHI with any persons that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional or spiritual care, including, but not limiting to family, friends, clergy and patient advocates. I also agree that the provider, his/her practice group and their agents may disclose my PHI to employers who arrange pay, directly or indirectly, for my medical treatment.

7. **Permission to Discuss Protected Health Information Regarding Minors:**

   I agree that Orthopedic & Spine PT may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI ant that I have no right to receive this information.

8. **Permission to Discuss Protected Health Information with Public Agencies:**

   I agree that Orthopedic & Spine PT, upon request by the following entities, disclose my PHI to public health agencies, law enforcement and the FDA.

9. **Notice of Privacy Practices:**

   I am aware that I can request a copy of "Notice of Privacy Practices" which sets forth this provider's privacy practices and my right regarding privacy of my PHI upon request.

Patient Signature_____ Date_____

Orthopedic & Spine Physical Therapy, P.C.

Denise Didio Buher, P.T.

NAME _____ REFERRING MD _____

Please indicate the primary reason you chose to come to Orthopedic & Spine PT

(Please check all that apply)

- ☐ **My doctor specifically recommended Orthopedic & Spine PT**

  MD Name _____

- ☐ **I chose Orthopedic & Spine PT from a list my MD provided me**

- ☐ **I am a previous Orthopedic & Spine patient**

- ☐ **A family member, friend or co-worker recommended Ortho & Spine**

  Name(s)_____

- ☐ **My Case Manager recommended Orthopedic & Spine**

- ☐ **My home therapist recommended Orthopedic & Spine**

- ☐ **Listed on my Insurance Website/Provider Directory**

- ☐ **On-line search led me to Orthopedic & Spine PT**

- ☐ **Social Medic Channels:** Facebook, Twitter, etc

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