



Patient Information

Patient Name: _____ SS#: _____ Birth Date: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Preferred Telephone #: _____ Preferred Cell#: _____

M F Single Married Other _____ Employed UnEmployed Retired Disabled Student

Would you like an appointment reminder? Call Text E-mail

E-mail address: _____

Have you ever had Physical Therapy before? Yes No If so, when: _____

Is this accident related? No Yes, _____

Are you currently or have recently been under the care of a home health agency? No Yes, please list the name and phone number of the company: _____

Referring Physician: _____ Telephone: _____

How did you hear about us? Returning patient ☺ Physician Family Member Friend Other _____

Emergency Contact: _____ Telephone: _____ Relation: _____

Primary Insurance: _____

Are you the Guarantor? Yes No – If NO, please fill out information below.

Guarantor's Name: _____ DOB: _____ SS# _____ M F

Telephone: _____ Address: _____

Patient Relation: Spouse Parent/Guardian Other

Secondary Insurance:

Are you the Guarantor? Yes No – If NO, please fill out information below.

Guarantor's Name: _____ DOB: _____ SS# _____ M F

Telephone: _____ Address: _____

Patient Relation: Spouse Parent/Guardian Other

I have read and verified the above information is correct and true. I hereby consent to treatment and authorize the release of pertinent medical information to my physician(s), insurance carrier(s), and O² Physical Therapy.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

DATE



FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with our patient account representative. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- **Payment is due at the time of service** unless other arrangements have been made in advance. We will look to the adult accompanying a minor for payment of all services rendered to minor patients.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will review your insurance benefits and file your insurance claims for you.
- If your account becomes delinquent after repeated attempts by our office to collect, we will send your account to a collection agency. You will then be responsible for an additional 35% collection fee.
- **MEDICARE PATIENTS:** As required by CMS, treatment sessions provided in the office setting is 2-3 times/week for 12-18 visits and requires the professional skills of a qualified physical therapist to perform or supervise the treatment. Services continuing beyond these parameters will be based on the complexity of the case.

You are responsible for notifying the receptionist of all scheduled doctor appointments.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

DATE

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment and follow-up among the multiple healthcare directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time-to-time, and that I may contact this organization at any time at the address above to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have carefully read and understand my rights outlined in the *Notice of Privacy Practices* above.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

DATE



Orthopedic & Occupational
Physical Therapy

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Estimated Height: _____ Estimated Weight: _____

Please check any conditions listed that you are experiencing and/or have experienced:

_____ Heart Problems	_____ Diabetes
_____ High Blood Pressure	_____ Headaches/Migraines
_____ Low Blood Pressure	_____ Epilepsy
_____ Chest Pain and/or Discomfort	_____ Seizures
_____ Bowel / Bladder Incontinence	_____ HIV / AIDS
_____ Other: _____	

Please comment on any conditions checked above:

Do you have a pacemaker? Yes No

Please list any surgeries:

Please list medications you are taking **pertinent** to this diagnosis:

Please list any medications you are taking **NOT related** to this diagnosis:

I hereby consent to treatment and authorize the release of pertinent medical information to my physician and/or insurance carrier(s).

Patient Signature: _____ Date: _____

Therapist Signature: _____