Orthopedic
Physical Therapy, Inc.

PATIENT DEMOGRAPHICS FORM

Last Name: _____ First: _____ Middle: _____

DOB: _____ Social Security#: _____ Sex: _____ Marital Status: _____

***Parent/Legal Guardian Name (if Child is under 18 years old):* _____**

Address: _____

_____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email Address: _____

Spouse Name: _____ Spouse Phone: _____

Referring Physician: _____ PCP/Family Physician: _____

IN CASE OF EMERGENCY (PERSON NOT RESIDING WITH PATIENT):

Name: _____ PH: _____ Relationship to Patient: _____

HEALTH INSURANCE: Subscriber Name & DOB (if not yourself): _____

AUTO INFORMATION and/or WORKER's COMPENSATION INFORMATION:

Date of Accident: _____ State of Accident: _____ Date You First Sought Treatment: _____

Auto: _____ Work Related: _____ Other (explain): _____

Claims Adjuster Name and Number: _____

PAYMENT and AUTHORIZATION INFORMATION*: You and/or your insurance company (if applicable) will be billed for covered services, and any unpaid balance will be the responsible party signing this form. Parents and guardian (s) are responsible with regards to a minor. The balance of the account will be due and payable if the insurance company has not paid within 45 days of if Worker's Compensation has not paid within 60 days. I hereby authorize Orthopedic Physical Therapy, Inc to release medical information to the insurance company (ies). Also, by my signature and copies thereof, I authorize payment directly to Orthopedic Physical Therapy, Inc of benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney or agency for collection, I will be responsible for attorney fees which are usually 33.33% of the unpaid balance.*

Patient/Legal Guardian Signature: _____ Date: _____

Name: _____ Date: _____

Medications

What medicines (prescriptions and/or over the counter), vitamins, supplements, and herbs do you take (regularly as needed)? If none (write N/A) _____

Name	Dose	How Often?	What is it for?

Medical History

What Medical conditions do you have?

- ☐ Diabetes Type I or II
- ☐ High blood pressure/hypertension
- ☐ High cholesterol
- ☐ Heart Disease
- ☐ History of stroke
- ☐ History of heart attack
- ☐ Hepatitis A, B, or C
- ☐ Liver Disease _____
- ☐ Pancreatitis
- ☐ Kidney disease
- ☐ Breast disease
- ☐ Blindness
- ☐ Intersex condition _____
- ☐ Thyroid Disease
- ☐ Migraines
- ☐ Blood clots
- ☐ Chronic pain _____
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Automimmune disease
- ☐ Epilepsy
- ☐ Traumatic Brain Injury
- ☐ Pituitary Adenoma
- ☐ Alzheimer's or Dementia
- ☐ Hearing impairment
- ☐ Hemorrhoids
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Asthma
- ☐ COPD or emphysema
- ☐ Tuberculosis (TB)
- ☐ Cancer _____
- ☐ HIV or AIDS
- ☐ HSV (Herpes)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ PCOS
- ☐ Incontinence
- ☐ IBS

Other medical conditions not listed: _____

Surgical History

What surgeries have you had in the past? (Write what year in the blank)

- Appendix removal ____
- Tonsil's removal _____
- Hernia repair _____
- Gall bladder removal _____
- Orthopedic _____
- Breast lumpectomy _____
- Unilateral mastectomy _____
- Breast reduction _____
- Bilateral mastectomy
- Hysterectomy _____
- Oopherectomy _____
- Metoidioplasty _____
- Phalloplasty _____
- Scrotoplasty _____
- Breast implants_____
- Orchiectomy _____
- Vulvoplasty _____
- Vaginoplasty _____
- Tracheal shave _____
- Facial surgery _____
- Body contouring _____

Other surgeries not listed: _____

January 2024

ORTHOPEDIC PHYSICAL THERAPY, INC.
Place initial (s) in provided boxes

☐ **INSURANCE:** You are responsible to know the details of your insurance benefits such as visit limits, authorization, and/or out of network benefits. Upon scheduling your initial evaluation your insurance coverage will be verified. After verification of your coverage has been made, the patient care coordinator will discuss your co-payment and/or co-insurance amount due at each visit**. Payment** is required before starting treatment. **Regardless of your situation, you are ultimately responsible for payment of your bill. Payments may be made by check, credit card or cash.**

☐ **CANCELLATIONS: Cancellation of appointments must be made 24 hours before scheduled appointments. Unless there are unusual circumstances, a cancellation fee of $125.00 will be charged.** Payment for this fee will be collected from the patient on their next visit. If this occurs again, the patient will be charged and may be taken off our schedule and placed on a waiting list. **All appointments and cancellations must be made by phone or in person**

☐ **LITIGATION ACCOUNTS WITH ATTORNEYS:** Orthopedic Physical Therapy **WILL NOT HOLD LITIGATION ACCOUNTS FOR SETTLEMENT**. You must make arrangements with the Office Manager for payment of these accounts.

☐ **COPIES OF RECORDS: All requests for copies must be accompanied by a signed release. Upon receipt of copies, payment for said copies are due in full. A fee sheet is available.**

☐ **PURCHASING SUPPLIES:** When purchasing a supply from Orthopedic Physical Therapy, payment must be made at the front desk when picking up the supply. The patient will receive a receipt that can be used for insurance purposes. Orthopedic Physical Therapy does not file claims with insurance companies for supplies. Payment for custom orders is required at the time order is placed.

☐ **NON-COVERED PROCEDURES:** Services not covered by your insurance company (**i.e dry needling, orthotics, or supplies** etc.) are your responsibility. If your therapist suggests one of these procedures, the fee will be your responsibility. Please sign the waiver form and make your payment prior to treatment.

Signature of Patient or Representative: _____ **Date:** _____

MEDICAL SERVICES AGREEMENT

I hereby authorize Orthopedic Physical Therapy, Inc. to render medical services to **me**/*my minor child* named _____ and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all the charges arising for the treatment of the above-named patient. If this contract is referred to an attorney for collection, I agree to pay all attorney fees and court costs incurred. There will be a **$35.00** charge for checks returned due to insufficient funds. I hereby consent to any medical treatment and evaluative procedures as the licensed physical therapist considers being necessary or advisable. I understand this may include, but not limited to orthopedic evaluation, modalities or manual treatment. I also hereby consent to have my medical records sent to the following:

PCP: _____ **Referring MD/Other:** _____

Signature of Patient or Representative: _____ **Date:** _____

Acknowledgment of Privacy Practices Notification

Our Notice of Privacy Practices tells you how our practice may use and disclose medical information about you. From time to time, the terms of our notice may change. If we change our notice, you may ask for a revised copy. I _____ (insert name of patient or legal guardian) have been given a copy of the Notice of Privacy Practices as provided by Orthopedic Physical Therapy, Inc. I understand that I may ask questions about any information contained in the Notice of Privacy Practices, and I also understand I may request a copy for my records.

***Patient Signature*:** _____ **Date:** _____

Authorized Representative of Patient or Legal Guardian: _____

Relationship to Patient: _____ **Date:** _____