

ORTHOPEDIC PHYSICAL THERAPY, INC.

Place initial (s) or mark in provided boxes.

- INSURANCE:** You are responsible for knowing 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:** Cancellations must be made 24 hours before scheduled appointments. A cancellation fee of \$135.00, per every 30 minutes, may 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. Arrivals greater than 15 minutes past scheduled time will be treated as a late cancel and are subject to the cancellation fee. In these situations, we cannot guarantee that you will be seen *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. Payment is due at time of services rendered.
- COPIES OF RECORDS:** All requests for copies must be accompanied by a signed release. Upon receipt of copies, payment for said copies is due in full. A fee sheet is available.
- SUPERBILLS AND BILLS:** A fee of \$.50 per page will be collected from the patient, if printed. Electronic copies can be emailed free of charge.
- 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 the 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 or *my minor child named* _____ and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company (if provided) 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 to be necessary or advisable. I understand this may include, but is not limited to orthopedic evaluation, modalities or manual treatment. I also hereby consent to having 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) acknowledge a copy of the Notice of Privacy Practices has been made available 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 of my records.

Patient or Representative Signature: _____ Date: _____

Relationship to Patient _____



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: _____

Choose only ONE of the following reminders: Text Email Phone

Would you like to receive our monthly newsletter email please circle your choice: YES or NO

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 (prescription 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?

- | | | |
|--|---|---|
| <input type="radio"/> Diabetes Type I | <input type="radio"/> Thyroid Disease | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Diabetes Type II | <input type="radio"/> Migraines | <input type="radio"/> Allergies |
| <input type="radio"/> High Blood Pressure/Hypertension | <input type="radio"/> Blood clots | <input type="radio"/> Asthma |
| <input type="radio"/> High Cholesterol | <input type="radio"/> Chronic Pain _____ | <input type="radio"/> COPD or Emphysema |
| <input type="radio"/> Heart Disease | <input type="radio"/> Arthritis | <input type="radio"/> Tuberculosis (TB) |
| <input type="radio"/> History of Stroke | <input type="radio"/> Osteoporosis | <input type="radio"/> Cancer _____ |
| <input type="radio"/> History of Heart Attack | <input type="radio"/> Autoimmune Disease | <input type="radio"/> HIV or AIDS |
| <input type="radio"/> Hepatitis A, B, or C | <input type="radio"/> Epilepsy | <input type="radio"/> HSV (Herpes) |
| <input type="radio"/> Liver Disease _____ | <input type="radio"/> Traumatic Brain Injury | <input type="radio"/> Endometriosis |
| <input type="radio"/> Pancreatitis | <input type="radio"/> Pituitary Adenoma | <input type="radio"/> Fibroids |
| <input type="radio"/> Kidney Disease _____ | <input type="radio"/> Alzheimer's or Dementia | <input type="radio"/> PCOS |
| <input type="radio"/> Breast Disease _____ | <input type="radio"/> Hearing Impairment | <input type="radio"/> Incontinence |
| <input type="radio"/> Blindness | <input type="radio"/> Hemorrhoids | <input type="radio"/> IBS |
| <input type="radio"/> Intersex Condition _____ | | |

Other medical conditions not listed: _____

Surgical History

What surgeries have you had in the past and in what year?

- | | | |
|-----------------------------|----------------------------|-----------------------|
| Appendix removal _____ | Breast Reduction _____ | Breast Implants _____ |
| Tonsils removal _____ | Bilateral mastectomy _____ | Orchiectomy _____ |
| Hernia repair _____ | Hysterectomy _____ | Vulvoplasty _____ |
| Gall bladder removal _____ | Oophorectomy _____ | Vaginoplasty _____ |
| Orthopedic _____ | Metoidioplasty _____ | Tracheal Shave _____ |
| Breast lumpectomy _____ | Phalloplasty _____ | Facial Surgery _____ |
| Unilateral mastectomy _____ | Scrotoplasty _____ | Body Contouring _____ |

Other surgeries not listed: _____