

## Patient Information

Date \_\_\_\_\_  
Patient Name \_\_\_\_\_  
*(Last Name, First Name, Middle Initial)*  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Sex:  Male  Female  
Age \_\_\_\_ Date of Birth \_\_\_\_\_

Referring Physician(s) \_\_\_\_\_  
Date of last Doctor Visit \_\_\_\_\_  
Date of next Doctor Visit \_\_\_\_\_  
Date of Onset \_\_\_\_\_  
Related to Accident?  Work  Auto  Other  N/A  
Employed:  Full-Time  Part-Time  Retired  Not working  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Marital Status:  Single  Married  Other  
Student:  Full-time  Part-Time  Not a Student  
How did you hear about OSR?  Doctor \_\_\_\_\_  
 OSR Staff \_\_\_\_\_  Other \_\_\_\_\_  
 Family/Friend  Email  Mailer  Internet  Insurance

## Responsible Party

Name \_\_\_\_\_  
*(Last Name, First Name, Middle Initial)*  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

## Insurance Information

Name of Insurance Company \_\_\_\_\_  
Insurance Co Phone Number \_\_\_\_\_  
Insurance Co Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Insured's Phone \_\_\_\_\_  
Sex:  Male  Female Date Of Birth *(mm/dd/yy)* \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Relationship to Insured:  Self  Spouse  Child  
ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_

## Emergency Contact Information

Relative/Friend \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

Relative/Friend \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_

## Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient's Age \_\_\_\_\_

Patient Occupation \_\_\_\_\_

When did the pain start? \_\_\_\_\_  
*(Approximate Date)*

## Health History

### How did the pain start?

- |   |  |
|---|--|
| <input type="checkbox"/> Suddenly           | <input type="checkbox"/> Pulling         |
| <input type="checkbox"/> Gradually          | <input type="checkbox"/> Injured at work |
| <input type="checkbox"/> Lifting            | <input type="checkbox"/> Bending         |
| <input type="checkbox"/> No apparent reason | <input type="checkbox"/> Other           |

### What activities make the pain worse?

- |  |  |
|--|--|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Bending forward   |
| <input type="checkbox"/> Exercise (after)  | <input type="checkbox"/> Bending backwards |
| <input type="checkbox"/> Sitting           | <input type="checkbox"/> Coughing          |
| <input type="checkbox"/> Walking           | <input type="checkbox"/> Sneezing          |

### What reduces the pain?

- |  |   |
|--|---|
| <input type="checkbox"/> Lying down          | <input type="checkbox"/> Pain pills         |
| <input type="checkbox"/> Sitting             | <input type="checkbox"/> Injection for pain |
| <input type="checkbox"/> Standing            | <input type="checkbox"/> Muscle relaxants   |
| <input type="checkbox"/> Walking             | <input type="checkbox"/> Nothing            |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Other              |

### How long have you had this pain?

\_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks

### How long have you had similar pain?

\_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Weeks

### Have you had any of these diagnostic tests?

- |            |                              |                             |            |
|------------|------------------------------|-----------------------------|------------|
| X-rays     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| CT scan    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| EMG/NCV    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| MRI        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| Arthrogram | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |

### Have you been hospitalized for your problem?

Yes  No Date: \_\_\_\_\_

### Have you had surgery for your problem?

Yes  No Date: \_\_\_\_\_

### Have you had any other surgery performed?

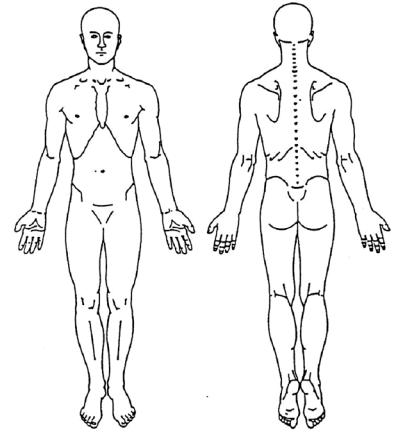
Yes  No Date: \_\_\_\_\_

### Pain/Symptoms

On the Body Diagram to the right, indicate your region of pain using the symbols below:

- (X) Sharp  
 (+) Numb/Tingling  
 (#) Dull/Aching  
 (B) Burning

\_\_\_\_\_   
 Pain Level  
 (0-10)



### What medications are you currently taking?

Yes/No

- |  |
|--|
| <input type="checkbox"/> <input type="checkbox"/> Allergies                    |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure          |
| <input type="checkbox"/> <input type="checkbox"/> Heart disease                |
| <input type="checkbox"/> <input type="checkbox"/> Stroke (CVA)                 |
| <input type="checkbox"/> <input type="checkbox"/> Cancer or tumors             |
| <input type="checkbox"/> <input type="checkbox"/> Lung problems                |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis-joint difficulties |
| <input type="checkbox"/> <input type="checkbox"/> (Ir)regular headaches        |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness-blackouts          |
| <input type="checkbox"/> <input type="checkbox"/> Seizures-nerve disorders     |
| <input type="checkbox"/> <input type="checkbox"/> Visual problems              |
| <input type="checkbox"/> <input type="checkbox"/> Menstrual problems           |
| <input type="checkbox"/> <input type="checkbox"/> Immunity disorders           |
| <input type="checkbox"/> <input type="checkbox"/> Gout                         |
| <input type="checkbox"/> <input type="checkbox"/> Are you pregnant?            |
| <input type="checkbox"/> <input type="checkbox"/> Joint replacement            |

Yes/No

- |  |
|--|
| <input type="checkbox"/> <input type="checkbox"/> Night sleep disturbance                  |
| <input type="checkbox"/> <input type="checkbox"/> Change in bowel or bladder habits        |
| <input type="checkbox"/> <input type="checkbox"/> Change in stool color or rectal bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Increased thirst or hunger               |
| <input type="checkbox"/> <input type="checkbox"/> Frequent urination                       |
| <input type="checkbox"/> <input type="checkbox"/> Indigestion or heartburn                 |
| <input type="checkbox"/> <input type="checkbox"/> Nausea or vomiting                       |
| <input type="checkbox"/> <input type="checkbox"/> Changes in memory                        |
| <input type="checkbox"/> <input type="checkbox"/> Unusual fatigue-weakness                 |
| <input type="checkbox"/> <input type="checkbox"/> Fever or chills                          |
| <input type="checkbox"/> <input type="checkbox"/> Frequent or easy bruising or bleeding    |
| <input type="checkbox"/> <input type="checkbox"/> Frequent cramping                        |
| <input type="checkbox"/> <input type="checkbox"/> Do you have pain 24 hrs?                 |
| <input type="checkbox"/> <input type="checkbox"/> Do you awaken from pain?                 |
| <input type="checkbox"/> <input type="checkbox"/> Do you smoke? _____ #/Day                |
| <input type="checkbox"/> <input type="checkbox"/> Do you drink? _____ #/Day                |

What other types of doctor/health care providers have you seen for this condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Financial Policy, Release of Information, Assignment of Benefits

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.

Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services are due at the time of service.

You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service.

If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, copay, until all claims have been processed. Payment is due upon receipt of our bill.

All health plans are not the same and do not cover the same services. We will do our best to determine what services are covered by your insurance and let you know if there is a recommended treatment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be “not covered” and we are unaware or you do not have authorization, you will be responsible for the complete charge.

## Payments and Patient Signature

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.

Patient accounts carrying a balance longer than 30 days are subject to a minimum monthly payment of \$75 or 25% of the outstanding balance due, whichever is larger.

There is a \$50.00 service fee for all returned checks.

### Fees Policy

A \$30.00 fee will be charged for all “No Shows”. Cancellations without a 24-hour notice will be assessed a \$15 Fee. These fees are not reimbursable by insurance and are considered due at your next visit.

I have read and understand the financial policy of OSR Physical Therapy and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.

I authorize the release of information necessary for treatment, payment & health care operations.

I also authorize assignment of benefits for services rendered by OSR Physical Therapy.

Date \_\_\_\_\_

Patient/Responsible Party Signature

\_\_\_\_\_

## Patient Information and Signature

*Please Carefully Review the OSR Physical Therapy Notice of Privacy Practices Booklet Prior to Signing Below*

I have read and understand the OSR Physical Therapy *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 below to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Please contact us for more information:**

OSR Physical Therapy  
41125 N. Daisy Mountain Dr., Suite 121  
Anthem, AZ 85086  
623-551-9706

**For more information about HIPAA or to file a complaint:**

The US Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, DC 20201  
Toll Free: 1-877-696-6775

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## Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

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Date	Initials	Reason

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