Welcome to OSR Physical Therapy.

Please fill out this form completely. Thank You!

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 ______________________

Cell Phone ______________________

Relative/Friend ______________________

Home Phone ______________________

Cell Phone ______________________

Patient Health History

Please fill out this form completely. Thank You!

Patient Information

Date ______________________

Patient Name ______________________

Patient's Age ______________________

Patient Occupation ______________________

When did the pain start? ______________________
(Approximate Date)

Health History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing
- ☐ 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?

Test			
X-rays	☐ Yes	☐ No	Date ____________
CT scan	☐ Yes	☐ No	Date ____________
EMG/NCV	☐ Yes	☐ No	Date ____________
MRI	☐ Yes	☐ No	Date ____________
Arthrogram	☐ Yes	☐ No	Date ____________
Injections	☐ Yes	☐ 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		Yes/No	
☐ ☐	Allergies	☐ ☐	Night sleep disturbance
☐ ☐	Diabetes	☐ ☐	Change in bowel or bladder habits
☐ ☐	High blood pressure	☐ ☐	Change in stool color or rectal bleeding
☐ ☐	Heart disease	☐ ☐	Increased thirst or hunger
☐ ☐	Stroke (CVA)	☐ ☐	Frequent urination
☐ ☐	Cancer or tumors	☐ ☐	Indigestion or heartburn
☐ ☐	Lung problems	☐ ☐	Nausea or vomiting
☐ ☐	Arthritis-joint difficulties	☐ ☐	Changes in memory
☐ ☐	(Ir)regular headaches	☐ ☐	Unusual fatigue-weakness
☐ ☐	Dizziness-blackouts	☐ ☐	Fever or chills
☐ ☐	Seizures-nerve disorders	☐ ☐	Frequent or easy bruising or bleeding
☐ ☐	Visual problems	☐ ☐	Frequent cramping
☐ ☐	Menstrual problems	☐ ☐	Do you have pain 24 hrs?
☐ ☐	Immunity disorders	☐ ☐	Do you awaken from pain?
☐ ☐	Gout	☐ ☐	Do you smoke? ______ #/Day
☐ ☐	Are you pregnant?	☐ ☐	Do you drink? _______ #/Day
☐ ☐	Joint replacement		

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

____
____
____
____

Medical Assignment of Benefits and Financial Policy

Please read this document in its entirety

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

____

Privacy Practices

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 ____

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

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:

Date	Initials	Reason