ORTHOPEDIC & SPORT REHAB
OSR
PHYSICAL THERAPY

Welcome to OSR Physical Therapy.

Please fill out this form completely. Thank You!

Patient Information

Date _____

Patient Name _____

(Last Name, First Name, Middle Initial)

Sex: ☐ Male ☐ Female

Date of Birth _____

Address _____

City/State/Zip _____

Cell Phone _____

Email Address _____

Social Security Number _____

Marital Status: ☐ Single ☐ Married ☐ Other

How did you hear about OSR? ☐ Doctor _____ ☐ OSR Staff _____

☐ Family/Friend ☐ Email ☐ Mailer ☐ Internet ☐ Insurance ☐ Other _____

Referring Physician(s) _____

Date of last Doctor Visit _____

Date of next Doctor Visit _____

Related to Accident? ☐ Work ☐ Auto ☐ Other ☐ N/A

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not working

Employer _____

Emergency Contact Information

Relative/Friend _____

Home Phone _____

Cell Phone _____

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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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?

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?

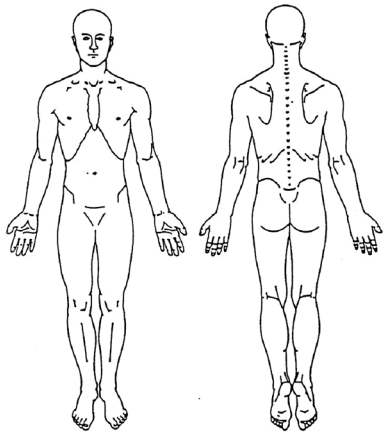
☐ Yes ☐ No Date: _____

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?

_____

_____

_____

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Patient Consent and Agreements

Please initial each section of this form. Thank You!

Consent to Treatment

I hereby consent to the evaluation and treatment of my condition to be completed at OSR Physical Therapy. I understand and agree that physical therapy and related services may involve bodily contact including the use of "hands on" examination and treatment procedures to aid in my recovery.

_____

Consent to Treat a Minor

I hereby give my consent to OSR Physical Therapy to evaluate and treat the minor child whose information has been provided in this registration.
I understand that OSR Physical Therapy strongly encourages parent or legal guardian participation in the initial appointment in order to understand the provided treatment, and to provide informed consent to the treatment plan. I recognize the importance of attending this initial appointment with my minor child. If I am unable to attend, I will accept responsibility to contact the evaluating therapist directly with any questions or concerns related to the evaluation or specified treatment.

_____

Fees Policy

I understand that I will be charged a fee for missed visits if I do not provide advanced notice. A $30.00 fee will be charged if I cancel past the 3:00pm the day before my appointment, and a $50.00 fee will be charged for all "No Show" appointments. These fees are not reimbursable by insurance and are considered due at my next visit.

_____

Notice of Privacy Practices - *Please Review the OSR Therapy Notice of Privacy Practices Booklet*

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.*

_____

Authorization for Media Release - *Please Review the OSR Therapy Authorization for Publication of Testimonial Policy*

I hereby authorize OSR Physical Therapy to publish my testimonial and/or photo(s), in all media (print, electronic, etc.) and for all types of advertising, publicity, promotion and other trade purposes for OSR, its products and services.
My name and additional identifying information may be revealed in conjunction with my testimonial and/or photograph.
I understand that I am not authorizing the use of my 1) detailed personal demographic information (address, birth date, etc.), 2) protected health information, aside from my name, likeness and any details about my physical therapy care and/or health history that I choose to provide in the form of a testimonial.

I consent, and I authorize OSR Physical Therapy to release my testimonial and/or photograph. ☐
I do not give consent, nor do I authorize OSR Physical Therapy to release my testimonial and/or photograph. ☐

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

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Medical Assignment of Benefits and Financial Policy

Please read this document in its entirety. Thank You!

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 Fees

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.

Patients that do not cancel their appointment by 3:00pm the day before their appointment will be assessed a $30.00 fee.
A **$50.00 fee** will be charged for all "No Shows."
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.

Patient/Responsible Party Signature _____ **Date**_____