WELCOME TO ORTHOCARE PHYSICAL THERAPY CENTER

Hello there,

Thank you for choosing Orthocare Physical Therapy Center to meet your Physical Therapy needs.

In this packet, you will find key information and forms. Here, you will also get answers to some FAQs so that we can make each of your PT visit a success. Of course, if you have additional questions, we are always happy to answer them and help!

The Forms

As a new patient, we require you to complete some basic paperwork. Please review these documents thoroughly and complete them as accurately as possible:

- New Patient Registration Form – this has some basic information about yourself as well as your insurance. This form will help us learn more about you and also make sure that all the insurance claims are processed accurately and on time. No one wants likes to be stuck with an unexpected/unpaid bill!.
- Patient Health Questionnaire – this form will give us an insight on your current health status. During the initial assessment, our Doctor of Physical Therapy will review this information with you to ensure the most comprehensive care possible.
- Policy and Consent Forms – our "Attendance policy" and "Notice of privacy practice forms" should answer your queries about: PT attendance requirements as well as about: what, why, how, and when your personal health information is used. Both of these forms need to be reviewed and signed before initiating any care.

Helpful Information

- A valid prescription and/or referral from your physician maybe required for all your therapy visits. Please contact our office for further confirmation.

- Your first visit will include a thorough evaluation and plan for treatment. Please allow about 1.5 hours for this first visit. Come dressed in comfortable clothing (something you would wear for exercising).

- Documentation - Your therapist will send a copy of the evaluation findings to your referring physician. Throughout the course of your treatment, your physical therapist will also attempt to proactively maintain appropriate contact with the physician. Please keep your therapist informed about any upcoming visits with the doctors so they can send updated progress reports as appropriate.

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- Insurance coverage - Before initiating PT, we will contact your primary insurance company to verify eligibility for PT. However, we highly recommend that you also contact your insurance company separately to confirm said coverage.

- Payments - Co-payments, if applicable, and coinsurance balances are due at the time of each visit. These balances are estimated based on your individual insurance policy and coverage. Please be prepared to make this payment at each visit. We gladly accept payments in form of cash, checks, as well as credit cards. Please review the financial policy outlined in the registration packet for further details.

- Secondary insurance – Please note that we do not file secondary insurance claims unless Medicare is your primary insurance.

- Attendance - Please see our attendance policy for further details on “no-shows”, “cancellations”, and “rescheduling” policies.

- Request for copies of medical records - There is a MINIMUM charge of $10.00 for a copy of your Medical Records. Additional per page fee may apply.

- Motor vehicle accident - If your therapy visits are a result of a motor vehicle accident or personal liability claim, please be aware that we do not participate in third party claims. If your health insurance doesn’t cover your complete charges, you are responsible to pay at the time of each visit.

- Feedback - We appreciate and welcome constructive criticism. We would love to hear your feedback – whether positive or negative - anything we can do to make things better!

PATIENT REGISTRATION FORM Date: _____

Name (First, Middle, Last): _____

Address: _____ Apt #: _____

City_____ State _____ Zip Code _____

Date of Birth (mm/dd/yyyy): ____/____/_____ Sex: _____ Social Security Number: ____-____-_____

Phones: Home _____ Work: _____ Cell: _____

Email: _____ Occupation: _____

Employer Name & Address: _____

Employer Address: _____

Emergency Contact: _____ Relationship_____ Phone _____

Responsible Party: _____ Relationship _____ Phone _____

Referring Physician Name _____ Diagnosis _____

With whom may we discuss your account or medical information? _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance: _____
Policy # _____ Group # _____
Subscriber Name_____ Relationship _____ DOB_____
In-Network Benefits: Co-pay _____ Deductible: __Y __ N Deductible Met: _____
Out-of-Network Benefits: Co-insurance _____ Deductible _____
Out-of-pocket max: _____ Visits/year _____ Visits used _____ Visits Authorized _____

Secondary Insurance: _____
Policy # _____ Group # _____
Subscriber Name_____ Relationship _____ DOB_____
In-Network Benefits: Co-pay _____ Deductible: __Y __ N Deductible Met: _____
Out-of-Network Benefits: Co-insurance _____ Deductible _____
Out-of-pocket max: _____ Visits/year _____ Visits used _____ Visits Authorized _____

Motor Vehicle Accident Information	Worker's Compensation Information
Date of Accident: _____	Is this injury related to work? ___ Yes ____ No
Nature of Accident: _____	Date of injury: ___/____/_____
Attorney: _____	WC Contact/Claims Mgr:_____
Phone: _____	Phone: _____

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PATIENT REGISTRATION FORM Date: _____

FINANCIAL POLICY

I have been notified and understand the following financial policies and responsibilities:

- I accept full financial responsibility for treatment received at this facility.
- I understand that payment of pre-determined office visit co-pay and co-insurance estimates are due at the time of service.
- I understand that my insurance may only cover a percentage of my total Physical Therapy bill. I agree to pay Orthocare Physical Therapy Center all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party insurance plan, or other payor source, on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.
- If there is balance remaining at the end of treatment, we will send one courtesy statement to you. I understand payment is due within 30 days from the date I am billed. Account balances are subject to a monthly service charge of 1.5%.
- I understand that I will be charged a fee of $50.00 if I do not cancel atleast 24 hours prior to my scheduled appointment time.
- I understand that a "No-Show" for scheduled appointment will result in $50.00 charge to my account.
- I understand that I am responsible for notifying the business office of any address or insurance changes to my account.
- I allow my credit card on file to be charged for any / all expenses accrued throughout my treatment at Orthocare Physical Therapy Center, LLC not limited to copays, co-insurance, deductibles, supplies, and no-show/cancellation fees.

Signature _____ Date: _____

HIPAA POLICY

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights related to protecting my personal health information. I understand that my personal information will be used to:

- Help manage and administer the health care treatment received
- Run the organization
- Obtain payment for rendered health services
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests (if applicable)
- Respond to lawsuits and legal actions (if applicable)

I acknowledge that I received, read, and understand the NOTICE OF PRIVACY PRACTICES which contains a thorough description of the uses and disclosures of my private health information.

Signature _____ Date: _____

PATIENT ACKOWLEDGMENT AND AUTHORIZATION OF RELEASE

The above information is true to the best of my knowledge. I authorize Orthocare Physical Therapy Center, LLC to apply for insurance benefits on my behalf. I understand that I am financially responsible for any balance. I also authorize Orthocare Physical Therapy Center or insurance company to release any information required to process my claims.

Signature _____ Date: _____

CONSENT TO TREATMENT

I consent to receiving outpatient physical therapy services for myself (or my child) and any ancillary services that are deemed medically necessary or appropriate by my physical therapist.

Signature _____ Date: _____

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PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Evaluation Date: _____

SUBJECTIVE

1. General Info: Age: _____ years Weight: _____ lbs Height: ____ ft ___ in
2. Please list the symptoms for which you are seeking PT:_____
3. When did your symptoms start? _____
4. How did your symptoms start? _____
5. Is the current injury related to:
   ☐Work ☐ Motor Vehicle Accident ☐ Previous injury/exacerbation ☐ Sports ☐ Post Surgical ☐ Other _____
6. Are your symptoms: Improving ____ Getting worse____ Staying the same ____
7. Have you ever had these symptoms before? Yes ___ No____If yes, please describe: _____
8. Have you ever had testing for these symptoms? (*check all that apply)*
   XRays ___ MRI ___CT Scan ____ EMG/Nerve Conduction Studies ____Other _____
   Results: _____
   Have you ever had treatment before for these symptoms? Yes_____ No____ If Yes, please describe:
   - Medication: Beneficial? Yes __No __Explain:_____
   - Physical Therapy: Beneficial? Yes __No __Explain:_____
   - Other: Beneficial? Yes __No __Explain:_____
9. Have you ever had surgery for this condition? Yes _____ No _____ If yes, Date of surgery: _____
   What surgical procedure was performed? _____

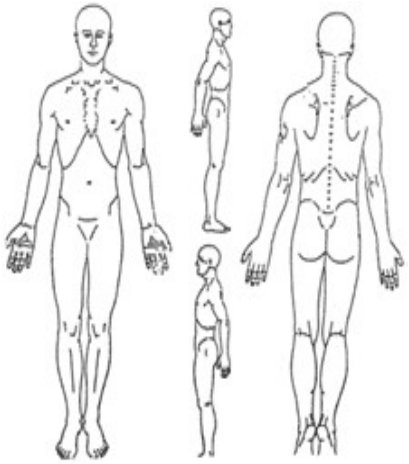
PAIN/SYMPTOM DESCRIPTION

1. On a scale from 0-10 (0 = "no pain" & 10 = "worst pain imaginable"), what is your pain level?
   At best: ____ At worst: _____ On average: _____

2. Please describe your discomfort:
   □ Constant □ Intermittent □ Ache □ Deep □ Superficial □ Dull □ Sharp
   □ Cramping □ Shooting □ Burning □ Numbness/Tingling □ Decreased Feeling
   □ Other: _____

3. Please check any other symptoms you might have:
   □ Stiffness □ Loss of Motion □Pressure □ Swelling □ Popping □ Clicking
   □ Giving way □ Locking □ Spasms □ Dizziness □ Fainting□ Nausea

4. What makes your symptoms better?_____
5. What makes your symptoms worse? _____



Please indicate the location(s) of your discomfort

FUNCTIONAL/SOCIAL HISTORY

1. What is your current living arrangement? □ Alone □ Spouse □ Partner □ Family □ Other: _____
2. Does your home have stairs? □ Yes □ No If Yes, # of stairs: _____

EXERCISE	STRESS LEVEL	SOCIAL HABITS
○ None	○ Low	Smoking Packs a day: _____
○ 1-2 x Week	○ Medium	Alcohol Drinks per week: _____
○ 3-4 x Week	○ High	Latex Allergy: ___Yes ___No
○ 5+ x Week		

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Patient Name: _____ DOB: _____ Evaluation Date: _____

3. Please list your TOP THREE functional activities that you were able to complete prior to this injury but are having difficulty completing currently in an efficient, typical, competent, and expected manner
   (i)_____ (ii) _____ (iii)_____

WORK HISTORY

1. Occupation: _____ Currently working? Yes __ No ___
2. If Yes, □ Full Duty □ Limited Duty: Restrictions: _____
3. What are your job duties? (*Check all that apply*)
   □ Sitting □ Computer Work □ Bending □ Heavy Lifting □ Traveling □ Standing □ Reaching □ Crawling □ Twisting
   □ Walking □ Pushing/Pulling □ Gripping/Pinching □ Other: _____
4. Does your current injury impact your work? If so, please describe _____

MEDICAL HISTORY

In terms of your general health, please check ALL that apply:

□ Allergies	□ Recent Nausea/Vomiting	□ Heart Palpitations
□ Metal Implants/Artificial Joints	□ Seizures/Epilepsy	□ Chest Pain/Angina
□ Respiratory Problems	□ Recent Vision Changes	□ Hernia
□ Recent Headaches	□ Recent Dizziness/Fainting	□ Depression
□ High Blood Pressure	□ Recent Change in Bowel/Bladder Habits	□ Surgeries
□ Hypoglycemia	□ Intolerance to Cold/Heat	□Kidney Problems
□ Unexplained Weight Loss/Gain	□ Pregnancy (Currently)	□ Heart Disease
□ Diabetes I or II	□ Recent Unexplained Fatigue	□ Numbness/Tingling in Hip/Buttocks Area
□ Heart Attack	□ Ringing of the Ears	□ Liver/Gallbladder Problem
□ Osteoarthritis	□ Fibromyalgia	□ Recent Fractures
□ Osteoporosis	□ Night Pain	□ Rheumatoid Arthritis
□ Pacemaker	□ Pain with Cough/Sneeze	□ Anemia
□ Cancer	□ Stroke/TIA	

5. Have you had any **falls** in the past 12 months? □ Yes □ No If Yes, how many? _____
   Please describe the nature of the fall(s) and any injuries from it:
   _____

Clinic Notes:
Fall Risk: Yes___ No ___

MEDICATIONS

Please provide a list **all** of the medications [with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____
_____

Clinic Notes
□ See Attached List
_____
_____
_____

PATIENT GOALS FOR THERAPY

What are your **goals** for participating in Therapy? (I.E: performing household tasks without pain)

_____

SIGNATURE: To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ PT Signature_____ Date: _____

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PHYSICAL THERAPY ATTENDANCE POLICY

The staff at Orthocare Physical Therapy Center strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, our commitment to you is to provide each patient with a reserved time slot with a specific therapist in order to minimize wait time and assure continuity of treatment. While we are sensitive to the fact that an emergency may occur, please understand that cancellations, tardiness and absentees reduce our ability to help you recover and to accommodate the scheduling needs of other patients. As such, we request your full cooperation with the following company policy:

• If a patient is more than 15 minutes late for an appointment and fails to notify the clinic of the tardiness, treatment may be cancelled and a cancellation fee of $50.00 will be charged for missing the appointment.

• A scheduled appointment must be cancelled at least 24 hours in advance or a cancellation fee of $50.00 will be charged for that appointment. Of course, weather, illness, medical emergencies, and unusual work circumstances are considered.

• Failure to show up for a scheduled appointment without providing the clinic with 24-hour advanced notification of your absence will result in a $50.00 fee being charged for that appointment. Furthermore, 3 consecutive absences without advanced notification may result in the cancellation of all your remaining scheduled appointments and notification to your referring physician of the consecutive absences.

•. You, as the patient are responsible for the cancellation fee, not the insurance company or the designated third party payor.

• All cancellations and absences will be documented in your medical record and reported to your physician and insurance company or third party payor.

By signing below, I acknowledge that I have read the foregoing company policy and agree to its terms.

_____

Patient/Responsible Party Name (printed)

_____ _____

Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights related to protecting my personal health information. I understand that my personal information will be used to:

- Help manage and administer the health care treatment you receive
- Run the organization
- Obtain payment for your health services
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests (if applicable)
- Respond to lawsuits and legal actions (if applicable)

I understand that Orthocare Physical Therapy Center will not disclose my protected health information ("PHI") without my explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations, as stated above. Furthermore, Orthocare Physical Therapy Center will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES which contains a thorough description of the uses and disclosures of my private health information. I understand Orthocare Physical Therapy Center has reserved a right to change its Notice of privacy practices from time to time. I also understand that I may contact the organization at any time to request a copy of the most revised Notice of Privacy Practices.

Signature _____ Date: _____

AUTHORIZATION OF COMMUNICATION MEANS

We may need to contact you. Please inform us about your preferred method of communication:

1. Phone: _____.
   Do we have your permission to leave a confidential message at this number? ___Yes ___ No

2. Email: _____

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize Orthocare Physical Therapy Center to disclose my personal health information to the person(s) named below.

Name _____Relationship_____ Phone# _____

Name _____Relationship_____ Phone# _____

Patient/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions