OSPT

ORTHOPAEDIC AND SPORTS PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name (Last)________________________(First)_________________________(Middle)________

Social Security #____________________________Driver's License #______________State___________

Date of Birth:_____________ Age:______ Sex:_____M___F__ Marital Status: S M D W SEP

Address:____City________State__________Zip__________

Mailing Address:_________________________________City________State__________Zip__________

Home #__________________________Business #________________________Cell #_________________

Email ____

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Emergency Contact_____________________________________ Phone #____________________________

Address____________________________________City______________State_____________Zip_________

Relationship__________________________________

==

Employer_______________________________________Occupation:_________________________________

Address:____

City_________________________________State_______Zip________Phone #________________Ext_______

Employer (spouse)________________________________Occupation:__________________________________

Address____

City_________________________________State_______Zip________Phone#_________________Ext_______

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INSURANCE

Primary: _____________________________________

Name of Insured_______________________________

SS#____

Date of Birth_________________________________

Relationship 1=self, 2=spouse, 3=child, 4=other

ID#____

Group Name____________________________________

Group #_______________________________________

Secondary: _________________________________

Name of Insured_____________________________

Date of Birth_______________________________

Relationship 1=self, 2=spouse, 3=child, 4=other

ID #____

Group Name__________________________________

Group #_____________________________________

Patient Name (Last)__________________(First)___________Date_________

How did you hear about us? ____

Doctor(s) who sent you?______________________________ **Dominant Hand: Rt ☐ Lt ☐**

Reason for visit:____

DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURRED.

Date of Injury______________________________ **If not injury, give Date of Onset**__________________

Was injury or onset related to: Work: ☐ Auto: ☐ Other: ☐

If other, please explain____

How did the injury or onset occur? ____

Where did the injury/problem occur? ____

What body parts were injured? ____

____

Are you currently receiving any other care for the condition mentioned above? No ☐ Yes ☐ (if yes, list)

Have you ever received therapy in the past for the condition mentioned above? No ☐ Yes ☐ (if so, list)

Previous Treatment Received:_____________________________________ **Successful: No ☐ Yes ☐**

IF PATIENT IS A MINOR OR STUDENT

School Name, Address and Phone #____

Father's Name ______________________ **Date of Birth**________________**SS#**________________

Address____________________________ **City**_______________**State**__________**Zip**__________

Employer___________________________ **Work #**_____________________________**Ext**________

Mother's Name______________________ **Date of Birth**________________**SS#**________________

Address____________________________ **City**_______________**State**__________**Zip**___________

Employer____________________________ **Work #**_____________________________**Ext**_________

Patient Name (Last)________________(First)_____________Date_____________

HISTORY OF PRESENT ILLNESS

A) Location of your pain? (e.g. Low back, neck, groin, buttock, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel, other)

B) Severity of your pain? Rate your current pain on the following scale (check one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

C) Character of the pain? (e.g. Dull, sharp, achy, burning, throbbing, crampy, shooting, prickly, stabbing, other)

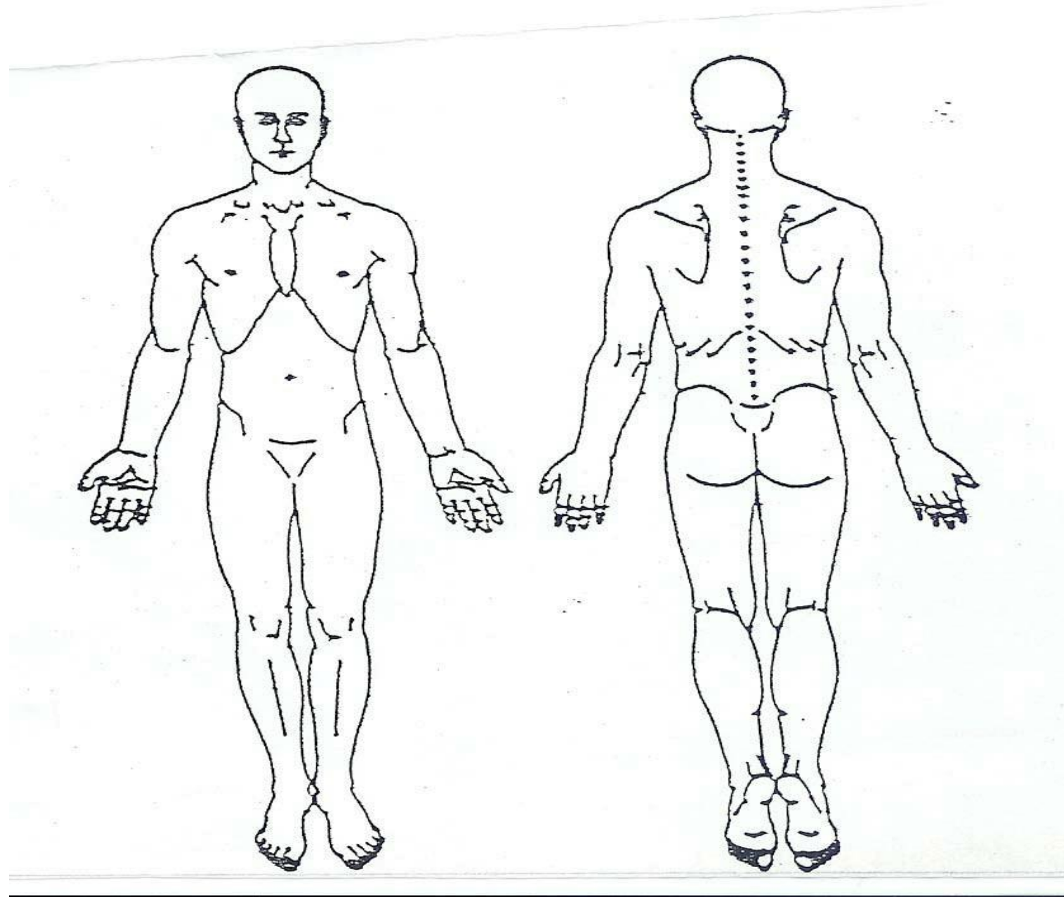
D) When do you feel pain and how long does it last? (Morning, afternoon, evening, increases over day, bending, climbing, squatting) Is the pain constant?

E) Associated symptoms? (e.g. swelling, locking, giving way, tenderness, fatigue, bruising, tingling, numbness, radiating pain-describe where?)

F) What makes your symptoms better? (e.g. Rest, heat, cold, elevation, Physical Therapy, braces, injections, special positioning, medications)

Please use the diagram on the following page to list the symptoms placing x's at location of worst pain you have experienced.

Patient Name (Last)____________________(First)______________________Date______



Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed:____Date:_________________

Patient Name (Last)_______________(First)_________________Date___________

Past Hospitalizations/Surgeries and Approximate Dates or None:____

____

____

Current Medical History *Please indicate if you have any of the following medical problems:*

	Yes	No		Yes	No		Yes	No
Arthritis	☐	☐	Diabetes	☐	☐	Numbness/Tingling	☐	☐
Osteoporosis	☐	☐	Anemia	☐	☐	Thyroid Problems	☐	☐
High Blood Pressure	☐	☐	Swelling in Ankles	☐	☐	Headaches	☐	☐
Heart Disease/Attack	☐	☐	DVT	☐	☐	Head Injury/concussion	☐	☐
Pacemaker	☐	☐	Seizures/Epilepsy	☐	☐	Hernia	☐	☐
Stroke	☐	☐	Fatigue/Weakness	☐	☐	Kidney/Bladder problems	☐	☐
Vascular Disease	☐	☐	Cancer/Tumor	☐	☐	Previous Fractures	☐	☐
Hypersensitive Heat/cold	☐	☐	Recent weight loss/gn	☐	☐	Previous Surgeries	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐	Metal in Body/Implants	☐	☐
Shortness of Breath	☐	☐	Hepatitis	☐	☐	Depression	☐	☐
Chronic Cough	☐	☐	Tuberculosis	☐	☐	Anxiety	☐	☐
Dizziness/Lightheaded	☐	☐	Recurrent Infection	☐	☐	Smoking	☐	☐
Nausea/Vomiting	☐	☐	Fever/Chills	☐	☐	Other	☐	☐

Allergies: **( ) None ( ) Contrast/Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine Shellfish ( ) Other:____**

Current Medications: **None ( )**

MEDICATION NAME	**DOSAGE**	**FREQUENCY**

Patient Name (Last) ____________ (First) _________________Date______________

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Orthopaedic and Sports Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and related services at the clinic. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Orthopaedic Sports and Physical Therapy and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Orthopaedic and Sports Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial: ____**

Assignment of Benefits

I authorize payment directly to Orthopaedic and Sports Physical Therapy, its subsidiaries and/or affiliates for services and to bill and release payment directly to Orthopaedic and Sports Physical Therapy, its subsidiaries and/or affiliates for any physical therapy services provided.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. **Initial:** _______

Payment Policy

I agree to pay Orthopaedic and Sports Physical Therapy its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Orthopaedic and Sports Physical Therapy and/or its affiliates or subsidiaries.

Initial: _______

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Your Health Information

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to obtain payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day business activities and management of the Company. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

We will share your health information with third party “business associates” that perform various functions or activities for or on behalf of our Company. For example, we may use a third party business associate to assist in billing or collection activities. Whenever an arrangement between our Company and a business associate involves the use or disclosure of your health information, we will have a written contract that contains terms that will protect the privacy of your health information.

Individuals Involved In Your Care or Payment for Your Care. Your health information may be used to communicate about you to a friend or family member who is involved in your care or who helps pay for your care. We may also inform your family or friends about your condition and that you have been seen in our facility. In addition, we may disclose health information about you to a friend or family member should an emergent situation arise while you are at our facility.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Incidental Disclosures. While we will take reasonable and appropriate steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during, or as an unavoidable result of, our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other individuals receiving services in the treatment area may see, or overhear discussion of your health information.

Other Uses And Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. For example, we will obtain your written authorization prior to using your health information for marketing purposes. If you change your mind after authorizing a use or disclosure of your information, you may revoke the authorization in writing at any time. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your health information. Except in limited circumstances, we are not obligated to agree to any restrictions you may request, however if we agree to restriction, we are bound to comply with it
- The right to inspect, and / or receive a copy of your health information, you may obtain a copy of your health information in an electronic format, if requested. A reasonable fee may be imposed.
- The right to restrict the disclosure of your health information regarding services for which you have paid out of pocket in full
- The right to receive confidential communications concerning your medical condition and treatment
- The right to amend and/or submit a request for corrections to your health information
- The right to receive an accounting of how and to whom your health information has been disclosed
- The right to receive a printed copy of this notice
- The right to be notified of any breach of your unsecured health information

OUR HEALTH INFORMATION DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties of privacy practices with respect to your health information. We also are required to abide by the privacy policies and practices that are outlined in this notice and notify you in the event of a breach of your unsecured health information.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. The revised policies and practices will apply to all of your protected health information that we maintain and we will be required by law to abide by these policies and practices. We will post

any revised notice in the reception area of our facility and a copy will be available for you upon your request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the company owner.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the Company by sending a letter outlining your concerns to:

Complaint Department

Orthopaedic and Sports Physical Therapy

19742 MacArthur Boulevard, Suite 110

Irvine, CA 92612

You may also file a written complaint with the Office of Civil Rights. No individual who files a complaint will be subject to retaliation by the Company.

Patient Name (Last) ________________ (First) _____________Date_________

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)
I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Orthopaedic and Sports Physical Therapy, its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. **Initial _____**
Patient Information and Data Sheet
I hereby acknowledge that the information I provided on the Patient Information Sheet is correct. **Initial:______**
Patient or Guardian Signature: **Date:**

Orthopaedic and Sports Physical Therapy

19742 MacArthur Boulevard Suite 110, Irvine, CA 92612

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