Orthopaedic and Spine Care NEW PATIENT FORM

PRINT CLEARLY

Name_____ **Social Security** _____

Address_____

City_____ **State**_____ **Zip**_____

Phone_____ **Cell**_____ **Email**_____

Birthdate_____ **Age**_____ **Sex:** M / F **Are you under 18?** Y / N

CONSENT FOR TREATEMENT OF A MINOR: As a parent and/or legal guardian, I authorize Orthopaedic & Spine Care PT to treat the minor named above while I am not present.

Parent/Guardian Signature_____ **Date**_____

Emergency Contact_____ **Telephone**_____

Referring Doctor_____ **Telephone**_____

Primary Care Physician_____ **Telephone**_____

Primary Insurance_____ **Telephone**_____

ID#_____ **Grp#**_____

Secondary Insurance_____ **Telephone**_____

ID#_____ **Grp#**_____

Was Injury Work Related?_____ **Injury Date**_____

Area(s) being treated_____

Who may we thank for referring you?_____

ASIGNMENT OF INSURANCE BENEFITS: I hereby authorize Orthopaedic & Spine Care Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Patient Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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

USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient or Personal Representative Signature **Date**

Orthopaedic and Spine Care Physical Therapy
PATIENT INFORMATION CONSENT FORM

I have read and fully understand ***Orthopaedic and Spine Care Physical Therapy's (OSCPT)*** Notice of Information Practices. I understand that ***OSCPT*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***OSCPT*** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ***OSCPT***'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Is it acceptable to leave a message for you at: Home Workplace Cell Phone Pager
(Circle any that you approve)

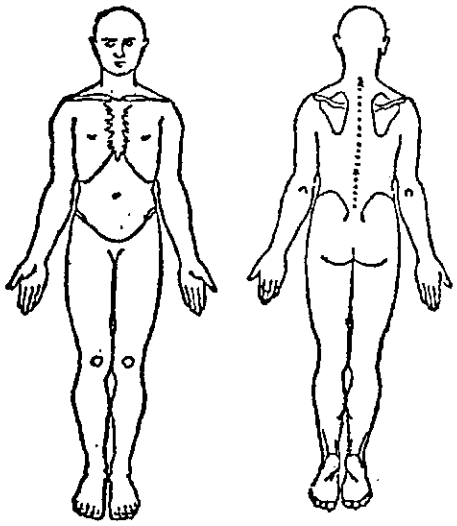
_____
Patient Name

_____
Patient Signature

_____
Date

OSCPT

MEDICAL HISTORY



Patient Name_____ Age_____

Type of Injury / Condition _____

Onset / Injury Date_____

Type of Surgery & Date _____

Next Doctor's Appointment?_____

Describe previous treatment for this condition_____

(Mark Pain on Diagram) →

Have you recently noted:

- ☐ Weight loss /gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Nausea / Vomiting
- ☐ Fever / chills / sweats
- ☐ Fatigue
- ☐ Numbness / Tingling

Have you EVER been diagnosed as having any of the following?

- ☐ Cancer
- ☐ Circulation problems, clots
- ☐ Chemical dependency, alcoholism
- ☐ Multiple sclerosis
- ☐ Ulcer
- ☐ Stroke
- ☐ Heart problems, Murmur
- ☐ Asthma, Breathing Problems
- ☐ Thyroid problems
- ☐ Rheumatoid arthritis
- ☐ Hernia
- ☐ Epilepsy, seizures
- ☐ High Blood Pressure
- ☐ Lung disease
- ☐ Diabetes
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Pacemaker/ Metal Implant

Do you have now or have you ever had any of the following?

- ☐ Headaches
- ☐ Abdominal Pain
- ☐ Change in Vision or Hearing
- ☐ Urinary Problems/Infections
- ☐ Unusual Shortness of Breath
- ☐ Pain at night
- ☐ Indigestion/Heartburn
- ☐ Injured Motor Vehicle Accident
- ☐ Repetitive Nausea, Vomiting
- ☐ Dizziness
- ☐ Long Standing Constipation
- ☐ Releasing Urine (coughing or sneezing)
- ☐ Easy Bruising/Bleeding
- ☐ Cramps in Legs when walking
- ☐ Fainting
- ☐ Any previous injury that may affect current care
- ☐ Neck Swelling/Lumps
- ☐ Recurrent Diarrhea
- ☐ Trouble Swallowing
- ☐ Hurried Need to Urinate
- ☐ Leg/Ankle swelling
- ☐ Insomnia
- ☐ Allergies / Skin sensitivity

Explain & give approximate dates for any items indicated above_____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type of pain: sharp / burning / aching / tingling / numbness / other _____

Does pain radiate to arms and / or legs _____

Rate your pain (average) on a 1-10 scale (1=minimal 10=severe)_____

Is there anything else you would like to include?_____

Patient Signature _____ **Date** _____

_____ **Therapist Use Only Below** _____

Baselines: Blood Pressure_____

Pulse_____

Respiration_____

Therapist Signature_____ **Date**_____