Ortho Rehab & Specialty Centers

PATIENT INFORMATION

Patient Name: last _____ First _____ MI ____

Address: _____City: _____ State: _____ Zip: _____

Phone: Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Web Address: _____

Date of Birth: _____ Marital Status: M S D W

Sex: M F Social Security #:_____

Patients Employer Name: _____ Address_____

City & State:_____

Spouse: _____ Occupation: _____

Work phone: _____ Cell: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Phone: ( ) _____

RESPONSIBLE PARTY INFORMATION (if other then patient)

Relation to Patient: Self Spouse Parent Other (for work comp.)

Name: Last _____ First _____ MI ____

Address: _____City:_____ State: _____ Zip: _____

Phone: Home: ( ) _____ Work: ( ) _____ ext. _____

Social Security #: _____-__-_____ Sex: M F Date of Birth: _____

Employer: _____ Address:

_____

City: _____ State: _____ Zip: _____

ACCIDENT/INFORMATION

Accident Type: None W/C Auto Other

Accident/Injury/Onset Date: _____Details and Reason for Visit: _____

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Attorney Name: _____ Phone ( ) _____

Attorney Address: _____

PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____
Family Physician: _____ Date of First Doctor Visit for this Injury: _____

Is an Attorney Involved in this Case? Y N

Have you had Surgery? Y N Number of Surgeries: 1 2 3 4

Are You Currently Taking Any Prescription or Non-Prescription Medications? Y N
Anti-inflammatory Muscle Relaxers Pain Medication
List Medications:

_____
_____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Chiropractor	Y	N	CT Scan	Y	N
EMG/NCV	Y	N	General Practitioner	Y	N
Massage Therapy	Y	N	MRI	Y	N
Myelogram	Y	N	Neurologist	Y	N
Occupational Therapy	Y	N	Orthopedist	Y	N
Physical Therapy	Y	N	Podiatrist	Y	N
Emergency Room Care	Y	N	X-Rays	Y	N

Do you now have or Have you ever had ANY of the following?

Asthma, Bronchitis, or Emphysema	Y	N	Severe or Frequent Headaches	Y	N
Shortness of Breath/ Chest Pain	Y	N	Vision or Hearing Difficulties	Y	N
Coronary Heart Disease or Angina	Y	N	Numbness or Tingling	Y	N
Do you have a Pacemaker?	Y	N	Dizziness or Fainting	Y	N
High Blood Pressure	Y	N	Bowel or Bladder Problems	Y	N
Heart Attack or Surgery	Y	N	Weakness	Y	N
Stroke/TIA	Y	N	Weight Loss/Energy Loss	Y	N
Congestive Heart Disease	Y	N	Hernia	Y	N
Blood Clot/Emboli	Y	N	Vericose Veins	Y	N
Epilepsy/Seizures	Y	N	Allergies	Y	N
Thyroid Disease or Goiter	Y	N	Any Pins or Metal Implants	Y	N
Anemia	Y	N	Joint Replacement Surgery	Y	N
Infectious Diseases	Y	N	Neck Injury/Surgery	Y	N
Diabetes	Y	N	Shoulder Injury/Surgery	Y	N
Cancer or Chemotherapy/Radiation	Y	N	Elbow/Hand Injury/Surgery	Y	N
Arthritis	Y	N	Back Injury/Surgery	Y	N
Osteoporosis	Y	N	Knee Injury/Surgery	Y	N
Gout	Y	N	Leg/Ankle/Foot Injury/Surgery	Y	N
Sleeping Problems/Difficulties	Y	N	Are You Pregnant?	Y	N
Emotional/Psychological Problems	Y	N	Do You use Tobacco?	Y	N

List any other information that would assist us in your care: _____
_____
_____

Are you aware of your diagnosis and prognosis as explained by your doctor? Y N Based on your awareness, What are your rehabilitation expectations/goals while in this program?
_____
_____

_____ _____
Patient/Guardian Signature Date

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for OR&SC to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party: X_____ Date: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major benefits to which I am entitled, including Medicare, private insurance, and third party payors to OR&SC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party: X_____ Date: _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Orthopedic Rehabilitation and Specialty Center.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize Orthopedic Rehabilitation and Specialty Center, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that OR&SC cannot collect a returned check fee by the other methods. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: OR&SC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operation generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities with copies for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Center Representative/Witness Date

HIPAA
NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that you medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice: _____

Contact person: _____

Phone Number: (501) 975-4040

Acknowledgement of Notice of Privacy Practices

*"I hereby acknowledge that I have received a copy of the practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way."*

_____

Patient or Representative Name (please print)

_____ _____

Patient or Representative Signature Date

- Patient refused to sign
- Patient was unable to sign because

Ortho Rehab
& Specialty Centers

_____

Ortho Rehab Newsletter

Thank you for choosing Ortho Rehab & Specialty Centers for your physical therapy services. If you would like to receive monthly newsletters describing typical physical therapy aliments, injuries, and general health related topics please fill out the information below. Our newsletters are based on scientific research and the best demonstrated practice for physical therapy. All email addresses will remain confidential.

First Name Last Name

@

Email Address