OAK RIDGE PHYSICAL THERAPY

Patient Medical History

Name: _____ Age: _____ Next MD visit for this problem: _____

Are you currently working: Full Duty ☐ Modified Duty ☐ Not Working ☐

Occupation: _____ Type of Work: (*examples are lifting, sitting, standing, computer work etc.)*

_____

CONCERNING YOUR CURRENT NEED FOR THERAPY:

When did your symptoms begin or become significantly worse? _____

How did your symptoms begin? _____

What are your current symptoms/complaints: _____

_____

What activities are difficult secondary to your symptoms/pain? _____

_____

What is your range of pain the last few days? *(0/10 is no pain, 5/10 is strong pain, 10/10 is worst imaginable pain)*

_____ lowest _____ highest

What are your goals/expectations with physical therapy treatment? _____

_____

What fitness activities or hobbies do you enjoy? _____

Do **YOU** have any previous history of:

High Blood Pressure	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Pacemaker/Internal Defib.	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Do you smoke?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Are you allergic to latex?	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No

Other _____ Height: _____ Body Weight: _____

How would you rate your overall health? Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Have you had any orthopedic surgical procedures or any previous orthopedic problems? Yes ☐ No ☐

If yes, please specify: _____

Have you been admitted to the hospital or had any other surgical procedures? Yes ☐ No ☐

If yes, please specify: _____

What medications are you taking and the reason? _____

_____

Who is your family physician and which group is he/she with? _____

Please list two daytime emergency contact persons and phone numbers:

1._____ 2. _____

_____ _____

Patient Signature **Date**

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Patient Registration

Please write legibly.

Last Name:	First Name:		MI:
Email:		Date of Birth:	
Address:			
City:	State:	Zip:	
Mobile Phone:	Home Phone:		
Employer:	City:		State:

Insurance Information *(please use this space if the patient is a minor or if coverage is through another person)*

Primary Cardholder Name:	Primary Cardholder Date of Birth:
Primary Cardholder Employer:	

***** Continued on Reverse

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PATIENT NAME:_____

LIFETIME BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I authorize direct payment of all insurance benefits including Medicare, private insurance, and any other health plans to Oak Ridge Physical Therapy for all covered therapy services and supplies provided to me during all courses of my treatment and care. I hereby authorize Oak Ridge Physical Therapy to release any and all information necessary, including medical records, to secure payment from the insurance company. A photocopy of this assignment is to be considered as valid as the original.

PATIENT INFORMATION CONSENT

I have read, or was given the opportunity to read, and fully understand Oak Ridge Physical Therapy's Notice of Patient Information Practices. I understand that Oak Ridge Physical Therapy 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 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 in writing. I also understand that Oak Ridge Physical Therapy will consider requests for restriction on a case-by-case basis. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

CONSENT FOR CARE AND TREATMENT

I hereby give consent for all treatments at Oak Ridge Physical Therapy, which in conjunction with the judgments of the attending provider may be considered necessary or advisable for the diagnosis or treatment of the above-named patient.

FINANCIAL POLICY STATEMENT

- As a courtesy we will bill your healthcare insurance carrier, **although you are responsible for all charges**. We will do our best to inform you of what we determine to be your proper co-pay, but it is your responsibility to pay whatever your insurance company does not pay us. We require that co-pays or coinsurance be made the day of service unless you have a payment plan set up. We accept cash, checks, and credit cards. You can receive a receipt for payments. **If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you.** If payment is made in excess of the balance of your account, we will refund the credit. Final balances less than twenty dollars ($20.00) or refunds less than twenty dollars ($20.00) will be considered a zero balance unless a refund is requested.
- If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Oak Ridge Physical Therapy.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Oak Ridge Physical Therapy, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
- The above financial policies do not apply for those patients who are considered Worker's Compensation patients. However, be advised as a Worker's Compensation patient, you may be held responsible for your charges if your claim is denied.

IF OAK RIDGE PHYSICAL THERAPY NEEDS TO CONTACT YOU, MAY WE LEAVE A MESSAGE? YES NO

WITH WHOM MAY WE DISCUSS YOUR HEALTH/INSURANCE INFO? SPOUSE ____or OTHER _____

Patient or Responsible Party signature - I agree to the above statements and policies	Date:
ORPT Representative:	Date:

OAK RIDGE PHYSICAL THERAPY

Appointment Reminder/Missed Appointment ($25 fee) Policy

Thank you for choosing Oak Ridge Physical Therapy. Our staff respects your time and makes conscious efforts to stay on schedule to avoid any delays to your personal schedule. We hope you understand that our time is also valuable as we strive to be available for patient appointments and operate our clinic successfully.

#1) To help remind patients of their appointments our computer system provides you a text message, email or voicemail the day before each appointment. This reminder will be coming from our Texas based software company with a **469** area code. Please indicate your preferred contact method for your appointment reminders.

- ☐ Cell phone text message
- ☐ Email
- ☐ Voicemail message: ☐ cell ☐ home ☐ work
- ☐ I do not wish to receive a reminder

#2) If we do not receive a **24-hour notice of cancellation** for scheduled appointments we reserve the right to charge a **$25.00 cancellation fee**. If you know that you will not be able to attend your appointment please call 644-0201. If after hours, you may leave a message on our office voicemail.

Please sign below to indicate that you understand this policy.

_____
Print Patient Name

_____ _____
Signature of Patient or Parent/Guardian *Date*