Orthopedic and Spine Physical Therapy
Patient Intake Form

Date: _____ Appointment Date/Time: _____ PT_____

Patient Name: _____
First Middle Last

Home Address: _____
Street City State Zip Code

Phone Numbers: _____ _____
Home Cell

DOB: _____ Sex: M/F Social Security #:_____

E-Mail:_____ Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

_____
If Minor: Responsible Party Relationship to Patient DOB

Home Address:_____
Street City State Zip Code

Referring Physician: _____ Primary Care Physician: _____

Reason for today's visit: _____

Is your injury related to an **automobile or work accident**? Yes No
Adjustors Name _____ / Contact Number _____

Have you had Physical Therapy or Chiropractic care **this year**? Yes No
Are you currently having Home Health or Skilled Nursing Care? Yes No

How did you hear about us? (Circle all that apply)
Workshop/Event Physician's Office Website/Search Engine Other _____

Patient Signature: _____ **Date:** _____

OSPT
Orthopedic & Spine Physical Therapy
www.osptpa.com

850 Walnut Bottom Road, Suite 306
Carlisle, PA 17013

P 717-241-2211
F 717-241-2240

Review of Systems

Have you had or do you experience unusual:

Cardiovascular System	**Yes**	**No**
Elevated Cholesterol	☐	☐
Sweating with Pain	☐	☐
Palpitations	☐	☐
Swelling of Extremities	☐	☐
History of Smoking	☐	☐
Difficulty Breathing	☐	☐
High Blood Pressure	☐	☐
Do you have a Pacemaker	☐	☐

Genitourinary System	**Yes**	**No**
Painful Urination	☐	☐
Blood in Urine	☐	☐
Incontinence	☐	☐
Frequency of Urination	☐	☐
Urinary Urgency	☐	☐
Sexually Transmitted Disease	☐	☐

Neurological System	**Yes**	**No**
Poor Muscle Coordination	☐	☐
Memory Lapse	☐	☐
Confusion	☐	☐
Head Trauma	☐	☐
Tremors	☐	☐
Neurological Disorder	☐	☐
Slurred Speech	☐	☐
Hearing/Visual Disturbances	☐	☐

Pulmonary System	**Yes**	**No**
Labored Breathing	☐	☐
Wheezing	☐	☐
Prolonged Cough	☐	☐
Sputum Production	☐	☐

Gastrointestinal System	**Yes**	**No**
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Yellow Skin (Jaundice)	☐	☐

Gastrointestinal System (cont)	**Yes**	**No**
Food Intolerance	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Change in Stool Color	☐	☐
Rectal Bleeding	☐	☐
Gall Bladder Problems	☐	☐
Liver Problems	☐	☐

Endocrine System	**Yes**	**No**
Excessive Hunger	☐	☐
Excessive Thirst	☐	☐
Large Volume of Urine	☐	☐
Excessive Sweating	☐	☐
Fatigue	☐	☐
Weakness	☐	☐
Thyroid Problems	☐	☐
Diabetes	☐	☐

Other Systems	**Yes**	**No**
Ear, Nose or Throat Problems	☐	☐
Other Skin Problems	☐	☐
Abnormal Swelling	☐	☐
Water Retention	☐	☐
Psychiatric Issues	☐	☐
Musculoskeletal Issues	☐	☐
Osteopenia	☐	☐
Osteoporosis	☐	☐
Cancer	☐	☐
Currently Pregnant	☐	☐

How many falls have you had in the past year? (Circle one)

0 **1** **2 or more**

Patient Name (Print or Type):_____ **DOB:**_____

Past Surgical Procedures

_____

_____

_____

_____

PLEASE COMPLETE ALL FOUR COLUMNS LISTED BELOW FOR EACH MEDICATION, HERBAL, AND VITAMIN/SUPPLEMENT THAT YOU ARE CURRENTLY TAKING

(PLEASE ATTACH ADDITIONAL PAGES AS NEEDED)

Medication Name	Dosage	Frequency	Route

Describe the problem for which you are seeking physical therapy treatment

_____

_____

_____

_____

_____

Patient Name (Print or Type):_____ DOB:_____

850 Walnut Bottom Road, Suite 306
Carlisle, PA 17013

P 717-241-2211
F 717-241-2240

OSPT
Orthopedic & Spine Physical Therapy
www.osptpa.com

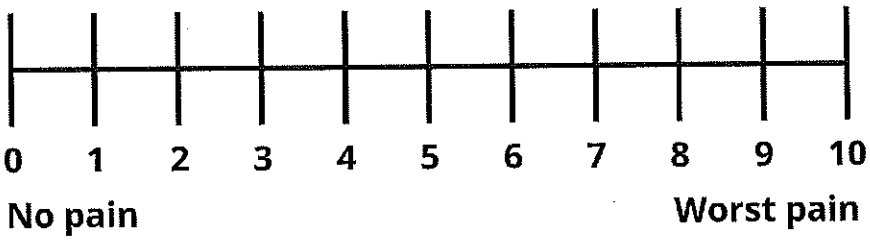
Pain Assessment

Please mark three (3) vertical lines on the scale below and label each line according to the following:

"C" CURRENT pain level

"L" LOWEST pain level in the past 72 hours

"W" WORST pain level in the past 72 hours



Rate your pain or pain relief from 0-10

Patient Name (Print or Type):_____ **DOB:**_____

OSPT
Orthopedic & Spine Physical Therapy
www.osptpa.com

850 Walnut Bottom Road, Suite 306
Carlisle, PA 17013

P 717-241-2211
F 717-241-2240

CONSENTS AND AUTHORIZATIONS

AUTHORIZATION TO RELEASE INFORMATION

I give my consent to Orthopedic & Spine Physical Therapy to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, and/or as required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to Orthopedic & Spine Physical Therapy only, and not to any party to whom such information is released. (Please refer to the Privacy Notice for a more complete description of such uses and disclosures. You have the right to review the notice prior to signing this consent.)

NON-COVERED SERVICES

I understand that some durable medical equipment such as foot orthotics, braces, and supplies such as electrodes and various pieces of exercise equipment for patients to use at home are generally not covered by insurance policies. If these items are needed, then payment for them will be my responsibility. I understand that I will be given the option to decline the opportunity to obtain durable medical equipment.

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical insurance plan, to issue payment directly to Orthopedic & Spine Physical Therapy for services rendered to me and/or my dependents. I understand that I am responsible for any amount not covered by my insurance carrier.

MEDICARE COMPLIANCE ASSURANCE NOTIFCATION

To our Medicare patients: All employees and managers at Orthopedic & Spine Physical Therapy undergo training so that they may understand and comply with government rules and regulations regarding Medicare. To read our Medicare Compliance Assurance Notification, please ask one of our staff members.

CANCELLATION/NO-SHOW POLICY

As a courtesy to our staff and other patients awaiting appointment times, we ask that you provide our office with 24 hour notice when needing to cancel appointment(s). Orthopedic & Spine Physical Therapy reserves the right to charge a $50 fee for late cancellation and/or no-show appointments.

TEXT MESSAGE REMINDERS

I agree to receive text messages to this mobile number ( ) _____ for the purpose of appointment reminders. I understand that standard message and data rates may apply.

I have read the above information and give my consent by signing below.

_____ _____

Patient Name (Type or Print) **Patient Date of Birth**

_____ _____

Signature of Patient or Responsible Party **Date**

UPDATED June 5, 2019

OSPT
Orthopedic & Spine Physical Therapy
www.osptpa.com

850 Walnut Bottom Road, Suite 306
Carlisle, PA 17013

P 717-241-2211
F 717-241-2240

FINANCIAL POLICY

Thank you for choosing Orthopedic & Spine Physical Therapy for your physical therapy needs. We are committed to providing you with the highest level of care at a fair price. Following are the terms of our Financial Policy.

PATIENT RESPONSIBILITY

Copayments are due at the time of service unless other arrangements have been made with our office in advance. Any copay, deductible and coinsurance balance that may be on your account will be billed to you monthly. For your convenience we accept cash, check, money orders, VISA and MASTERCARD. Failure to pay your balance may result in your discharge from our practice. If you have any questions or concerns regarding your payment responsibility and/or balance on your account, we are here to help. Payment plans are available upon request.

PAYMENT PLAN

We understand that insurance premiums are rising, as are patient responsibilities for payment of healthcare services (copays, deductibles and coinsurances). As a courtesy to you, we offer a variety of payment plans when your payment responsibilities become too high. To inquire about payment plans, please contact our billing office at **717-241-2211**.

RETURNED CHECKS

In the event that you have insufficient funds in your bank account to cover a check that you have submitted to us for payment on your account (returned check), a fee of $35 will be assessed and added to your account balance. If this happens, we will not be able to accept personal checks from you for payments on your account for 90 days.

INSURANCE VERIFICATION POLICY

You are required to provide our office with all forms of health care coverage prior to or at the time of your initial evaluation. Our office will take the necessary steps to submit charges to your insurance company for all services rendered in our facility. In cases where there is a secondary insurance company, we will submit any charges that are not paid by the primary insurance company to the secondary insurance company for payment. The remaining balance will be your responsibility. If at any time during your treatment your health insurance coverage changes, it is your responsibility to notify our office. Failure to do so may result in denials of coverage by your insurance company and you will be responsible for payment.

SELF PAY OPTIONS

If you do not have insurance coverage or have exhausted your insurance benefits for the current plan year, we will offer you a fair self-pay rate. This rate is in line with industry standards.

COLLECTION AGENCY

Accounts that are delinquent after 90 days will be placed with our collection agency. Accounts that are placed with our collection agency will be assessed a 30% collection fee. This amount will be added to your outstanding balance. Your account balance will be subject to collection fees, administration fees, attorney fees and or court fees as applicable.

Orthopedic & Spine Physical Therapy reserves the right to change the Financial Policy. You may request an updated copy at any time by asking our front office staff.

Patient Name (Type or Print) _____ **Patient Date of Birth** _____

Signature of Patient or Responsible Party _____ **Date** _____

850 Walnut Bottom Road, Suite 306
Carlisle, PA 17013

P 717-241-2211
F 717-241-2240

OSPT
Orthopedic & Spine Physical Therapy
www.osptpa.com

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) 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, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services. The Notice of Privacy Practices is NOT an authorization.

Orthopedic & Spine Physical Therapy has a Notice of Privacy Practices available for you at the front desk, posted in our waiting room, and posted on our website. Please ask our staff if you have any questions about this notice or if you would like to have a copy.

Please list the names of any individuals whom you permit to access your protected health information or make inquiries about your medical condition and treatment at Orthopedic & Spine Physical Therapy (i.e. spouse, parents, children).

_____

_____

_____

_____

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Orthopedic & Spine Physical Therapy's Notice of Privacy Practices.

_____ _____

Patient Name (Type or Print) **Patient Date of Birth**

_____ _____

Signature of Patient or Responsible Party **Date**

UPDATED JUNE 12, 2017