Orthopedic & Spine Physical Therapy
Consents & Authorizations Form

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits, including Medicare and/or other private insurance companies, be made directly to Orthopedic & Spine Physical Therapy for services rendered. If I am paid directly, I will promptly pay Orthopedic & Spine Physical Therapy all monies.

_____
Initials

Guarantee of Payment

I understand that payments designated as patient responsibility are due at time of service, and that payments toward deductible and co-insurance are *estimates*. The exact amount due will be known after all insurance claims process. Any balance remaining on my account will be billed to me monthly, and I guarantee I will pay the amount due by the billing statement due date. Any overpayment on my account will promptly be refunded.

_____
Initials

Certification of Information

I certify that the insurance coverage/payment information I have provided to Orthopedic & Spine Physical Therapy for payment, including but not limited to Medicare, private insurance carriers, or any other insurance carriers is accurate and truthful. I understand that if at any time during treatment my health insurance coverage changes, it is my responsibility to notify the office.

_____
Initials

Collection Agency

I understand that accounts that are delinquent after 90 days will be placed with a collection agency and assessed a 30% collection fee. This amount will be added to the outstanding balance on my account and subject to additional administration fees, attorney fees and/or court fees as applicable.

_____
Initials

Cancellation/No-Show Policy

As a courtesy to our staff and other patients awaiting appointment times, I understand that I must provide 24-hour notice when needing to cancel appointments. I understand that Orthopedic & Spine Physical Therapy reserves the right to charge a $50 fee for late cancellation or no-show appointments.

_____
Initials

Retuned Check Fee

I understand that in the event of a returned check, a fee of $35 will be added to my account balance.

_____
Initials

Appointment Reminders

I agree to receive appointment reminders via text message to (____)_____ (mobile number).
I understand that standard message and data rates may apply.

_____
Initials

_____ _____
Patient Name (printed) Date of Birth

_____ _____
Signature of Patient or Responsible Party Date

Orthopedic & Spine Physical Therapy

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 full 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 9/29/2020

Orthopedic & Spine Physical Therapy
Health History Form

Patient Name:_____ **Date of Birth:**_____

Medical History – Have you yourself ever experienced any of the following:

Heart Disease	Y N	Stroke	Y N	Osteopenia/porosis	Y N
Seizures	Y N	Abdominal Pain	Y N	Cancer	Y N
Shortness of Breath	Y N	Fatigue	Y N	Pregnancy (Current)	Y N
Bowel/Bladder Problem	Y N	Weakness	Y N	Pacemaker	Y N
Headaches	Y N	Diabetes (Type___)	Y N	Unusual Weight Loss	Y N
Numbness	Y N	Abnormal Swelling	Y N	High Blood Pressure	Y N
Dizziness	Y N	Psychiatric Issues	Y N	Tobacco Use	Y N

In the past 3 months, have you experienced any significant changes in your physical or mental health? Y N

Surgeries? Y N List: _____

How is your general health: Poor Fair Good Excellent (circle one)

List other health problems: _____

Current Problem – The problem for which you are seeking Physical Therapy treatment:

What is the main complaint?_____When did it start?_____

What started it (Injury, Surgery, Unknown, Work or Car Accident)?_____

Is it getting: Worse Better Staying the same (circle one)

What treatments have you had so far, and did they help? _____

Specifically, what makes you feel better?_____

Specifically, what makes you feel worse?_____

Is your pain: Constant Not Constant (circle one)

Are you worse in the: Morning Afternoon Evening (circle one)

Have you had: X-rays MRI CT Scan Nerve Test (circle all that apply)

What diagnosis have you been given by your doctor?_____

Are you currently working? Y N What are your job tasks?_____

Pain – Based on a 0 – 10 scale (0 is none, and 10 is the most severe), please rate your pain:

Now_____ Highest in the last 72 hours_____ Lowest in the last 72 hours_____

Current Medications –

Name:	Dosage:	Frequency:	Route:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact Information:

Name:_____ **Relationship:**_____ **Phone:**_____

Orthopedic & Spine Physical Therapy COVID-19 Questionnaire & Consent
This Information is Confidential & Will be Securely Managed

Name: _____Date: _____Date of Birth: _____

1. Have you had any of the first three symptoms, or a combination of one of the first three symptoms and another symptom listed, in the past 14 days?

☐ Fever over 100.4° Yes ☐ No ☐
☐ Persistent cough Yes ☐ No ☐
☐ Shortness of breath Yes ☐ No ☐
☐ Flu-like symptoms Yes ☐ No ☐
☐ Vomiting/Diarrhea Yes ☐ No ☐
☐ New loss of taste or smell Yes ☐ No ☐

If yes, how long have you had these symptoms? _____
If yes, have you been diagnosed and/or seen the doctor? Yes ☐ No ☐

2. Have you been in close contact, in the past 14 days, with an individual who had any of the first three symptoms or a combination of one of the first three and another symptom listed?

☐ Fever over 100.4° Yes ☐ No ☐
☐ Persistent cough Yes ☐ No ☐
☐ Shortness of breath Yes ☐ No ☐
☐ Flu-like symptoms Yes ☐ No ☐
☐ Vomiting/Diarrhea Yes ☐ No ☐
☐ New loss of taste or smell Yes ☐ No ☐

If yes, have they been diagnosed and/or seen the doctor? Yes ☐ No ☐

3. Have you, or a member of your household, tested positive for COVID-19 within the past 10 days, or are currently awaiting COVID-19 test results? Yes ☐ No ☐

4. Within the past 30 days have you traveled outside of Pennsylvania?
Yes ☐ No ☐
If yes, where? _____

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability. Thank you for assisting us in our endeavors to minimize exposure to COVID-19.

Thank you for your trust in our practice. As with the transmission of any infectious disease, like a cold/flu, you may be exposed to COVID-19 at any time or in any place. Be assured that we at Orthopedic & Spine Physical Therapy are following state and federal regulations and use universal precautions and disinfection protocols to limit the transmission of all diseases.

Cloth face coverings are required for patients, staff, and visitors in our office. Despite our careful attention to symptom screening, sterilization, and disinfection, there is still a chance that you could be exposed to an illness while in our office, just as you might be at the grocery store/favorite restaurant. We have taken measures to provide protection and social distancing in our practice. Due to the nature of certain procedures we provide, it is not always possible to maintain social distancing between our health care providers, staff, and patients at all times.

Although exposure is unlikely, do you accept these risks and consent to treatment?
YES NO (circle one) **Initials** _____