ORTHO SPORT
PHYSICAL THERAPY, INC.

Welcome. We will strive to provide you with the most courteous service and the highest quality of physical therapy care available. Please take time to read the following information, which should help you maximize the use of your time in physical therapy. Thank you.

CLOTHING: If you have a

- **Neck or shoulder injury**: Please wear or bring a sleeveless, or other loose fitting shirt.
- **Lower extremity injury**: Please wear or bring loose fitting shorts **and** athletic shoes.
- **Low back injury:** Please wear or bring loose shorts or sweat pants.

TREATMENT TIMES/SCHEDULING:

- **Length of appointment times:** Appointment last between 40 and 60 minutes each. If you have any time constraints, let your therapist know at the beginning of your appointment
- **Scheduling appointments in advance**: Please schedule at least 3 weeks in advance. Ask the receptionist or your therapist any questions about this.

WHAT YOU SHOULD EXPECT FROM OSPT:

- **Good communication:** Your therapist should explain your treatment plan, and should answer any questions pertaining to your injury and therapy
- **Timelines:** You should generally expect to be see on time. Sometimes other patients arrive with unexpected problems or complications, which may delay your therapist. However, this is relatively infrequent.
- **Written instructions:** Your therapist should give you written instructions for any exercises or other activities to be done at home that he has prescribed.

WHAT WE EXPECT FROM EACH PATIENT:

- **To be an active participant:** Since physical therapy is an active process, we expect each patient to perform some exercises and other activities prescribed to you by your therapist. Physical therapy is generally not successful when viewed as a passive treatment.
- **To arrive on time:** To receive full benefit of scheduled appointment time.
- **To cancel or reschedule your appointment:** Please contact us at least 24 hours in advance. This will help other patients in need o appointments.
- **To notify us about your Doctor's appointment**: So we can update your doctor.
- **To refrain from cell phone use**: It takes away from therapy time and is distracting.

OFFICE: 508-588-2800
FAX: 508-588-2881
102 WEST CENTER STREET
WEST BRIDGEWATER, MA 02379

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Date:____/_____/____

Patient Information:

Name: _____ Date of Birth: ____/____/_____

Address: _____
Street City State Zip Code

Home Phone:_____ Cell Phone: _____

Email: _____

Occupation: _____ Height: _____ Weight: _____

Dominant hand: **L or R** Sex: **M or F** Marital Status: **M S D W** # of Children: _____

If under 18 years of age, Parent or Guardian: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

Injury Information:

Diagnosis: _____

Is this a new injury or a chronic issue?: _____ When did you start experiencing symptoms?: _____

Injury/Surgery Date: _____ Cause of injury?:_____

Primary Care Doctor: _____

Referring Physician: _____

Have you ever had physical therapy before? Y or N If so, when?: _____

For this diagnosis or a different one?: _____

Insurance Information:

Health Insurance : _____ Member ID:_____

Policy Holder's Name: _____ Policy Holder"s DOB: _____/_____/_____

Secondary Health Insurance: _____ Member ID:_____

If applicable, please choose below AND provide ALL information:

☐ **Auto Insurance** ☐ **Worker's Compensation Insurance**

Claim Number: _____

Insurance Company: _____ Policy Holder: _____

Adjustor's Name: Adjustor's Phone: _____ext_____

Employer: _____

Employer Address: _____

Attorney Information:

Attorney Name: _____ Phone: _____

Address: _____ Fax: _____

Personal History:

List sports/exercises/hobbies you are actively involved in: _____

_____

Related past injuries: _____

Have you had any other intervention for this problem i.e. Chiropractor, acupuncture, etc.?

_____

Is your problem getting better/worse or staying the same since it started? _____

_____

What is your goal for physical therapy? _____

Past Medical History

Please circle the answer and add any others, please include date of incident

Cancer	**Yes or No**	_____
Pregnant	**Yes or No**	_____
Heart Disease	**Yes or No**	_____
Pacemaker/internal defibrillator	**Yes or No**	_____
High Blood Pressure	**Yes or No**	_____
Diabetes	**Yes or No**	_____
Headaches	**Yes or No**	_____
Fainting	**Yes or No**	_____
Gastrointestinal Issues	**Yes or No**	_____
Arthritis	**Yes or No**	_____
Dizziness	**Yes or No**	_____

Other: _____

Please list any past surgeries or injuries: _____

Please list any allergies: _____

What medications are you currently taking? _____

_____

Do you have a follow up appointment with your doctor? YES / NO When: _____

How did you hear about Ortho Sport Physical Therapy, Inc.: _____

The above information is true to the best of my knowledge.

Patient/Representative Signature: _____ **Date:** _____

ORTHO SPORT
PHYSICAL THERAPY, INC.

Date: _____

Name:_____

Current Medication(s) List:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

ORTHO SPORT
PHYSICAL THERAPY, INC.

Designated Individuals Authorization Form

I hereby authorize Ortho Sport Physical Therapy, Inc. to release my protected health information regarding my treatment and payment to the following individuals. I acknowledge that the identity of the following individuals must be made before release of any information.

Please give the name(s) of the individual(s) you will allow to receive any part(s) of your health information.

Designees names:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient signature: _____ Date: _____

Patient printed name: _____

ORTHO SPORT
PHYSICAL THERAPY, INC.

Acknowledgement of Ortho Sport Physical Therapy, Inc. Office Policies

The following are Ortho Sport Physical Therapy Inc.'s policies regarding scheduling, payments, and information releases. Please read carefully and be sure to ask for clarification if unsure.

Cancellation/ No Show Policy: All Cancellations/No Shows will be subject to a $40.00 fee for 2nd offense and a $75.00 fee for additional offenses (not covered by insurance). All balances will be due prior to your next scheduled appointment.

Insurance Benefits: All copays are due at the time of each visit. It is the patient's responsibility to know the physical therapy benefits provided by their health insurance including copayments, coinsurance amounts, applied deductibles and visit limits. Failure to notify Ortho Sport Physical Therapy of insurance inactivation may result in patient responsibility.

Payments: By signing this document, I am authorizing my insurance company or attorney to pay Ortho Sport Physical Therapy, Inc. for the professional services rendered. By signing this document, I acknowledge that I understand that I am responsible for the fees my insurance company does not pay on my claims (i.e. copayment, coinsurance, deductibles). I also acknowledge that I agree to pay the full amount of charges should it be that my condition is not covered by my policy or if for some reason my insurance/attorney refuse to pay the balance.

Treatment: By signing this document, I am giving Ortho Sport Physical Therapy, Inc. my permission to evaluate and treat the condition for which I am seeking services. I understand that the clinic and/or gym area are common areas accessed by other patients, gym members, and visitors and that as a result, there may be incidental contact with personal health information.

Release: I am authorizing Ortho Sport Physical Therapy, Inc. to release any pertinent information from my case to my insurance company or attorney to collect payment on my balance accrued at this office.

I certify that I have read and understand all of the office policies listed above.

Signature:_____ Date: _____

Printed name:_____

Witness signature: _____ Date: _____
(Signature of Authorized Clinic Representative)

Witness printed name: _____

ORTHO SPORT PHYSICAL THERAPY, INC.

NOTICE OF PRIVACY AND INFORMATION PRACTICES

In compliance with Federal Law, effective September 23, 2013

By signing this form, I acknowledge that I have reviewed

THIS CONSENT AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____

Patient Signature (or Representative) Date

_____

Patient Name(print)

_____

Date of Birth

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

OFFICE USE ONLY

A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Clinic Representative Date

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Services Provided Without Referral/ Authorization

As a member of _____, I understand that I have an obligation to obtain
(Name of HMO)

a referral/authorization from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a referral /authorization today, I will be responsible for and agree to pay the costs of all services provided should this visit be denied by my insurance.

I understand that this is my responsibility to make sure that Ortho Sport Physical Therapy receives the referral/ authorization required by my Primary Care Physician/ Health Insurance Plan.

Date of Visit: _____

Patients Name: _____

Signature: _____

_____
(Patient or Legal Guardian)

OFFICE USE ONLY

I am a contracting provider for the above Managed Care Plan. However, I have not received a valid referral , authorization and/or number from the patient's PCP or Health Insurance Company. This was communicated to the patient who agrees to assume financial responsibility for the services provided today, should the payment be denied by the health insurance, subject to provisions of existing agreement between Ortho Sport Physical Therapy, Inc and the patient's health insurer.

Practice Name: Ortho Sport Physical Therapy, Inc.

Physical Therapist Name (print): _____

Office Staff Name (print): _____

Office Staff Signature: _____

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