



Orthopedic & Spine Physical Therapy

Patient Information

Name _____ DOB ____ / ____ / ____ Age _____

Sex: Male Female Marital Status: Single Married Other

Social Security # _____ - _____ - _____ Best Phone # (____) _____ - _____

Billing Address _____ Physical Address _____

City/ State/ Zip _____ City/ State/ Zip _____

Employer _____ Work Phone # (____) _____ - _____

Referring Physician _____ E-mail address _____

Primary Care Physician (PCP) _____

Reason for today's visit _____ Date of onset _____

Emergency Contact, Legal Guardian, Spousal Information

Name _____ Phone # (____) _____ - _____

Relationship to patient _____

Billing Information

Please circle one: Insurance Worker's Comp Motor Vehicle Claim Self-Pay

Insurance name (if applicable): _____

For W/C or MVA-Claim #: _____ Date of Incident: _____

How did you hear about us? (Circle one):

Provider Referral Family member/ Friend Driving by Internet

Phone book Newspaper Magazine Other _____



Medical Screening Questionnaire

Please list any **prescription medications** you are currently taking, including pills, injections or skin patches (or if you have copy of them with you we can photocopy)

- 1. _____ 3. _____ 5. _____ 7. _____
- 2. _____ 4. _____ 6. _____ 8. _____

Over the Counter Medications you are taking. _____

Have you had a **physical exam** by your physician within the past year? Yes No

Have you been seen by a **Home Health Agency** within the last 60 days? Yes No

Do you have a **pacemaker**? Yes No

For women - Are you **pregnant**? Yes No

Do you **smoke**? Yes No

Do you use **caffeine**? Yes No # of cups coffee/soda per day? ____

Are you allergic/sensitive to **latex** Yes No

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

Major surgeries since birth:

Joint Replacements - List: _____

Joint Arthroscopic - List _____

Fractures or Fixation (plates, screws..) - List _____

Spinal Surgery - List: _____

Heart Surgery - List: _____

Other(s)- List: _____

Have you been seen by any of the following for your current condition?

Medical Doctor MD	Osteopath DO	Psychiatrist/Psychologist	
Massage Therapist	Chiropractor	Acupuncturist	Other Physical Therapist
Orthopedist	Neurologist	Dentist	Other _____

Check any of the following that are NEW or UNUSUAL for you.

Nausea/Vomiting	Dizziness	Fever/Chills/Sweats
Night Pain	Headaches	Unexplained Weight Change
Muscle Weakness	Numbness or Tingling	Constipation/Diarrhea
Bowel or Bladder Changes	Difficulty Swallowing	Difficulty Breathing
Blood in Stool/Urine	Night Sweats	Fatigue
Chest Pain/Angina		

How often do you feel stress is a significant factor in your life?

Never Seldom Regularly Always

Check if you currently have or previously had any of the following.

Ulcers	High Blood Pressure	Osteoporosis
Asthma	Gout	Rheumatoid Arthritis
Cancer	Seizures	Osteoarthritis
Diabetes	Stroke	Lung Disease
Heart Problems	Circulation Problems	Thyroid Condition
Other Illnesses _____		

Specify: _____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____

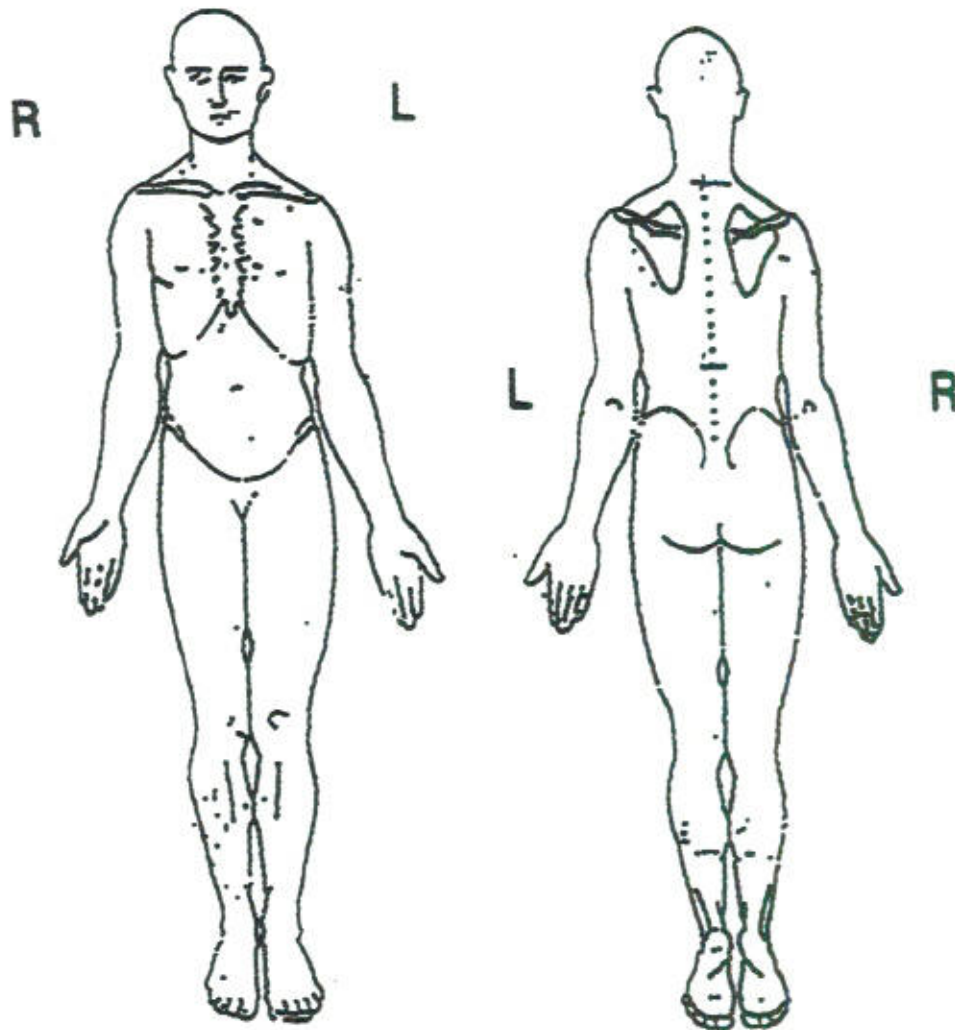


Orthopedic & Spine Physical Therapy

581 Main Street, Suite 1, Lewiston, ME 04240
Tel. (207)777-3002 Fax (207)777-3004

Pain Profile

Patient name: _____ Date: _____



Shade painful area(s), darker where more intense,
lighter where less intense.



OSPT Orthopedic & Spine Physical Therapy

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Patient Privacy Policy & Procedure Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.

Orthopedic & Spine Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services. We protect all patient information within the guidelines provided by federal, state, and local government.

Orthopedic & Spine Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Office Manager at 207-777-3002. You may also send a written complaint to the US Department of Health and Human Services.

I understand that 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. I also understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby consent to the use and disclosure of my personal health information for the purpose of carrying out treatment, obtaining payment and any administrative operations of the facility related to treatment or payment.

Signature _____

Patient/ Guardian

Date _____

Financial Policy for Orthopedic & Spine Physical Therapy

The following is our Financial Policy. We ask that all patients read and sign this policy, as well as complete our Patient Information Sheet prior to seeing the physical therapist. If you have any questions or concerns about our payment policy, please do not hesitate to ask.

Physical Therapy/Supplies

Orthopedic & Spine Physical Therapy will submit claims to your insurance company on your behalf. *Office visit co-payments are due at the time of service.*

Various supplies that you may need through the course of your physical therapy treatment may not be billable to your insurance, as they may not be a covered benefit and we are not a durable medical equipment provider. We ask that you pay for these devices at the time you receive the supply. Most insurers do not cover foot orthotics.

Medicare Beneficiaries

Orthopedic & Spine Physical Therapy will submit claims to Medicare part B on your behalf. The following Medicare guideline will be followed:

Initially, after every 10 sessions, and upon completion of your therapy, you will be asked to complete an outcome questionnaire to allow your therapist to document your functional status and progress.

Medicare with Companion Plans Coverage: Medicare will automatically forward your claims.
Medicare with any other Secondary Coverage: Orthopedic & Spine Physical Therapy will submit a claim to your secondary insurance.

Please provide all billing information at the time of your first visit. When your insurer(s) have paid their portion and have identified your responsibility, if any, a statement will be sent to you for payment. We ask that you pay this balance within 30 days.

We ask that you give at least 24 hours notice if you cannot make your scheduled appointment. It is the policy of Orthopedic & Spine Physical Therapy to remove your name from the therapist's schedule if you have no-showed for two consecutive appointments.

Assignment of Benefits: I, _____ authorize medical benefits to be paid directly to: **Orthopedic & Spine Physical Therapy, 581 Main Street, Suite 1, Lewiston, ME 04240.** I understand that I, the patient or financially responsible person, am responsible for charges not considered by my insurance.

I have read and I understand the contents of the above. I understand that I am entitled to a photocopy of this page.

Name _____
Please print name

Date _____

Please sign name

Effective 6/08/10