rehab advantage & sports medicine

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Olivia H. Martin, OTR/L
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- Physical therapy
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- Post-total joint rehabilitation
- Arthritis, bursitis & tendonitis
- Balance/vestibular dysfunction
- Headaches
- Musculoskeletal injuries
- Neurologic disorders
- Postsurgical rehabilitation
- Work injuries
- Back & neck problems
- Shoulder, elbow, knee & ankle injuries
- Incontinence

Patient Information

Patient's Full Name: _____ Sex: _____
(as it appears on insurance card)

Mailing Address: _____

City _____ State _____ Zip _____

Street Address (if different): _____

City _____ State _____ Zip _____

Home Phone Number: (_____)_____-_____ Cellular Number: (_____)_____-_____

Social Security Number: _____-_____-_____ (social is required to file insurance)

Date of Birth: _____-_____-_____ Marital Status: _____
Month Day Year

Referring Physician: _____

Primary Care Physician: _____

Date of Injury or Accident Date: _____-_____-_____
Month Day Year

Have you had any therapy this year? Yes _____ No _____ (Car Accident Yes _____ No _____)

Emergency Contact: _____

Phone Number: (_____)_____-_____ Cellular Number: (_____)_____-_____

Patient Employer: _____ (or guardian if patient is a dependent)

Employer Phone Number: (_____)_____-_____

Who may we thank for referring you to rehab advantage & sports medicine? _____

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Insurance Information

Please provide staff with copy of insurance card and drivers license.

Primary Insurance: _____

Phone Number: (_____)_____-_____ (usually located on back of card)

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured's Name: _____

Insured's Social Security Number: _____-_____-_____

Date of Birth: _____-_____-_____
Month Day Year

Policy Number: _____ Group #: _____

Copay: _____

Secondary Insurance: _____

Phone Number: (_____)_____-_____ (usually located on back of card)

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured's Name: _____

Insured's Social Security Number: _____-_____-_____

Date of Birth: _____-_____-_____
Month Day Year

Policy Number: _____ Group #: _____

Copay: _____

Authorization To Release Information: I hereby grant Rehab Advantage & Sports Medicine to release pertinent medical and/or billing records to my insurance company, attorney or physician, which is designated by me.

Assignment of Insurance Benefits: I hereby authorize Rehab Advantage & Sports Medicine direct payment of medical benefits, otherwise payable to me but not to exceed the charges stated on claim. I understand I am financially responsible to the provider for charges not covered by this assignment.

Authorization of Treatment: I hereby authorize Rehab Advantage & Sports Medicine provide the appropriate level of therapy care deemed necessary by the treating therapist and/or therapy assistant. A copy of this authorization shall be valid as the original …

Our office files insurance as a courtesy to the patient. It is your responsibility to follow up if they do not pay in a timely manner. We will be glad to provide you with paperwork to re-file if needed. *Please note that you are responsible for your co-pay at time of visit.* Your balance is determined by your insurance company (as noted on your EOB as "patient responsibility"). If you have not met your deductible, our office will work with you on a payment schedule (please notify our staff).

Signature of Patient or legal guardian: _____ Date: _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Rehab Advantage & Sports Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided, and*
- *A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- *The right to review the notice prior to signing this consent,*
- *The right to object to the use of my health information for directory purposes, and*
- *The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations*

I understand that Rehab Advantage & Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Rehab Advantage & Sports Medicine reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Rehab Advantage & Sports Medicine change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information: _____

_____

_____

_____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (continued)

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

As a courtesy to our patients, our office will bill your insurance carrier(s) for the services rendered by Rehab Advantage & Sports Medicine, Inc. Not all therapy services are covered under certain insurances, Medicare, or Medicaid. In some cases, the amount of eligibility and coverage can only be determined after the insurance carrier processes your claim. To minimize any out of pocket costs that may occur, we ask you to contact your employer/insurance carrier to expedite authorization of payment. The undersigned is responsible for all costs incurred including, but not limited to, deductible and co-pays, either through insurance or out of pocket expenses.

If our office does not receive payment in full within 60 days of rendered services, the patient, parent or legal guardian will be liable for payment. If litigation or collections is necessary to collect unpaid debts, the undersigned agrees to pay for all costs incurred.

I fully understand and accept the terms of this consent.

_____

Patient's Signature/Legal Guardian

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

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Initial Examination Orthopedic

Name: _____ *Date:* _____

Referred by: _____

Employment/Work (Job/School/Play): *(please check all that apply)*

Work Status:	*Unemployed ___*	*Working Full-time ___*	*Working light duty ___*
	Student ___	*Homemaker ___*	*Working Part-time ___*
	Disabled ___	*Retired ___*	

Occupation: _____

Your Work Involves: *(please check all that apply)*

Prolonged Standing ___	*Working with a bent neck ___*	*Lifting Light Objects ___*
Prolonged Sitting ___	*Frequent typing ___*	*Lifting Heavy Objects ___*
Prolonged Walking ___	*Repetitive overhead work ___*	*Carrying Light Objects ___*
Prolonged Driving ___	*Excessive reaching ___*	*Carrying Heavy Objects ___*
Prolonged forward bending ___	*Frequent hand Grasping ___*	*Repetitive pushing/pulling ___*
Exposure to vibrating tools ___	*Climbing ladders ___*	*Repetitive arm motions ___*
Exposure to temperatures ___	*Excessive stair climbing ___*	*Repetitive foot motions ___*

Other: _____

Medications & Allergies --
Please check or list all medications or allergies:

Non-Prescription:

No Medications ___	*Decongestants ___*	*Motrin ___*	*Advil/Aleve ___*
Excedrin ___	*Vitamins/minerals ___*	*Antihistamines ___*	*Herbal Supplements ___*
Tylenol ___	*Aspirin ___*	*Ibuprophen/Naproxen ___*	

Prescription:
No Medications ___
Other _____

Allergies:
No Known Allergies to Date ___
Other _____ _____

Surgical History-Please list any surgeries you have had, and if known include dates:
No Surgeries to Date___
1. _____ *Date:* _____ *2.* _____ *Date:* _____

3. _____ *Date:* _____ *4.* _____ *Date:* _____

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Initial Examination Orthopedic, continued ...

Past Symptom History Checklist-Within the past year, have you had any of the following

Fall without Injury

No Symptoms in Past Year ___
Dizziness/Blackouts ___
Cough (persistent) ___
Headaches ___
Difficulty Swallowing
Difficulty Walking ___
Chest Pain ___
Fatigue ___
Difficulty Sleeping ___
Heart Palpitations ___
Bowel problems ___
Excessive Sweating ___
Decreased coordination ___
Hearing Problems ___

Fall with Injury

Joint pain or swelling ___
Urinary problems ___
Nausea/vomiting ___
Weight gain (Unexplained) ___
Shortness of Breath ___
Tremors ___
Loss of Balance ___
Weakness in arms/legs ___
Weight Loss (Unexplained) ___
Loss of Appetite___
Vision Problems ___
Numbness in arms/legs ___
Pain at Night ___

Diagnostic Tests/Measures-Within the past year, have you had any of the following:
(please check all that apply)

No Diagnostic Testing ___
Stool Test ___
Mammogram ___
Ultrasound ___
Biopsy ___
X-Ray ___
Pulmonary Function Test ___
Spinal Tap ___
Bronchoscopy ___
Angiogram ___
Stress Test ___
MRI ___
Echocardiogram ___
Blood Test ___
Bone Scan __-
EMG/Nerve conduction ___
CT Scan ___
Arthroscopy ___
Urine Test ___
Pap Smear ___
EEG ___
EKG ___

Current Condition(s)/Chief Complaints:

Nature of Onset/Injury:

Motor Vehicle Accident ___ *Fall ___* *Unknown Onset ___* *Work Related Injury ___*
Traumatic Event ___ *Gradual Onset ___* *Ongoing/Chronic Condition ___*

Date of Onset: _____-_____-_____
Month Day Year

Briefly Describe What Happened: _____

_____

Chief Complaints or Problems: _____

_____

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Initial Examination Orthopedic, continued ...

Overall How Would you Describe the Intensity of your Symptoms?
Slight _____ Minimal _____ Moderate _____ Severe _____ Emergency _____

Overall How Frequent are Your Symptoms?
Intermittent (off & on) ____ Occasionally (sometimes) _____ Constant (all the time) _____

Have you ever had this problem before? Yes _____ No _____

What did you do for the problem? _____

_____

Did the problem get better? Yes ___ No ___ ***How long did the problem (s) last?*** _____

What makes your symptoms worse? _____

_____

What is your goal for Physical Therapy? _____

_____

Are you seeing anyone else for your problem? Yes ___ No ___
If yes, please check all that apply

Acupuncturist ___ Cardiologist ___ Chiropractor ___ Neurologist ___
Podiatrist ___ Family Doctor ___ Orthopedist ___ Massage Therapist ___
Rheumatologist ___ Other ___

Comments _____

_____

_____

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_____

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