OSTC
Orthopaedic & Sports Therapy Center

#1 West Medical Ct (940)692-4688
Wichita Falls TX 76310 (940)692-8388 FAX
www.OSTCWF.com

PATIENT NAME

FIRST: _____
PREFERRED NAME:_____
MIDDLE:_____
LAST:_____

ADDRESSES

PRIMARY ADDRESS
LINE 1: _____
LINE 2:_____
CITY:_____
STATE:_____ ZIP:_____

SECONDARY ADDRESS
LINE 1: _____
LINE 2:_____
CITY:_____
STATE:_____ ZIP:_____

OTHER INFORMATION

GENDER: MALE / FEMALE
DOB:_____
LANGUAGE: ENGLISH / SPANISH
OTHER:_____
DOMINANT HAND: LEFT / RIGHT
SSN: _____
DATE OF INJURY: _____
AREA INJURED: _____
WORK RELATED: Y / N

SCHOOL ATTENDING: _____
DO YOU CURRENTLY PARTICIPATE IN A SPORT: Y / N
WHAT SPORT: _____
WHERE: _____

RESPONSIBLE PARTY

(IF UNDER 18)

NAME:_____
ADDRESS:_____
_____
PHONE:_____
DOB:_____
SSN:_____
RELATION TO PATIENT:_____
PATIENT'S PRIMARY DR:_____
PATIENT'S REFERRING DR:_____

EMPLOYER INFORMATION

EMPLOYER:_____
ADDRESS:_____
_____
PHONE:_____
CONTACT:_____

PATIENT CONTACT INFORMATION

PHONE NUMBERS
HOME:_____ CELL:_____ WORK_____ OTHER:_____
E-MAIL:_____ PREFERRED METHOD OF CONTACT:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
NAME ON CARD: _____
SUBSCRIBER: _____
RELATION TO PATIENT: _____
SUBSCRIBER SSN: _____ SUBSCRIBER DOB: _____
INSURANCE ID #: _____ PLAN #: _____

SECONDARY INSURANCE: _____
NAME ON CARD: _____
SUBSCRIBER: _____
RELATION TO PATIENT: _____
SUBSCRIBER SSN: _____ SUBSCRIBER DOB: _____
INSURANCE ID #: _____ PLAN #: _____

EMERGENCY CONTACT

NAME: _____ PHONE(S): _____ RELATION: _____

***What made you choose OSTC for your care? Check all that apply: ___ Phonebook ___ Website ___ Friend ___Physical Therapist/Athletic Trainer ___ Doctor ___Prior treatment at OSTC**

***Have you had an interaction with a staff member from OSTC that made you want to choose OSTC? ___Yes ___No**

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PRIVACY PRACTICE NOTIFCATION

I have been given the opportunity to review the Privacy Practices of this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I give permission for Orthopaedic & Sports Therapy Center to release my medical information to the following people:

Name_____DOB_____Relation_____

Name_____DOB_____Relation_____

Name_____DOB_____Relation_____

Patient Name (PRINT)_____

Signature of Patient or Responsible Party_____

DATE_____

PLEASE READ, INITIAL, AND SIGN BELOW

_____ RELEASE OF INFORMATION

I authorize *Orthopaedic Associates (OA), LLP/OSTC*, to release any medical information requested by other physicians or representatives of local, state, or federal agencies; insurance companies; or other organizations or entities as may be required by said representatives for treatment or payment of claims arising out of this treatment/hospitalization as are due *Orthopaedic Associates, LLP/OSTC.*

_____ RELEASE OF PRESCRIPTION HISTORY

I understand this information is used in our electronic health records to avoid drug interactions. I authorize *Orthopaedic Associates (OA), LLP/OSTC* to collect this information.

_____ FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered plus any late charges or interest accrued on delinquent payments and I further agree that all amounts are due upon request and are payable to *Orthopaedic Associates, LLP/OSTC,* Wichita Falls, Texas. When the outstanding balance reaches thirty days past due (payment is due on day of service), interest is accrued at 10% APR. This will authorize and direct my lawyer to withhold from any recovery or settlement as a result of injuries, which I may have sustained, the amount of any reasonable professional fee due *OA, LLP/OSTC,* for serves rendered to me and to remit said amount to the said *OA/LLP/OSTC.* If you have a liability injury, such as a motor vehicle accident or other such injury where there is or will be a liability claim, if we file your insurance for you, then you will be responsible for repaying the insurance company.

_____ INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby assign and transfer to *Orthopaedic Associates, LLP/OSTC* any benefits payable to or for my benefit under hospitalization, sickness, or accident insurance, and any other insurance coverage; to include major medical or payment of such service rendered. I agree to cooperate, aid, and assist *Orthopaedic Associates, LLP/OSTC* in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I further assign and transfer to said *Orthopaedic Associates, LLP/OSTC* an interest in any cause of action I may be arising out of injuries directly or indirectly resulting in this period of treatment.

_____ NOTICE OF PRIVACY PRACTICES

I acknowledge that the Notice of Privacy Practices of *Orthopaedic Associates, LLP/OSTC* was made available for me to read.

Patient Name(PRINT)_____Signature_____Date_____

Responsible Party
Name (PRINT)_____Signature_____

ORTHOPAEDIC & SPORTS THERAPY CENTER

MEDICAL HISTORY INFORMATION

NAME:

_____ _____ _____ _____

LAST **FIRST** **MI** **JR/SR**

STREET ADDRESS: _____

GENDER: _____ MALE _____ FEMALE

DOMINANT HAND: _____RIGHT _____ LEFT

_____ _____ _____

CITY **STATE** **ZIP**

SCHOOL ATTENDING: _____

LANGUAGE:

_____ ENGLISH UNDERSTOOD _____ INTERPRETER NEEDED

LANGUAGE YOU SPEAK MOST OFTEN _____

EDUCATION:

HIGHEST GRADE COMPLETED (CIRCLE ONE)

1 2 3 4 5 6 7 8 9 10 11 12

_____ SOME COLLEGE / TECHNICAL SCHOOL

_____ COLLEGE GRADUATE

_____ GRADUTE SCHOOL / ADVANCED DEGREE

WHO REFERRED YOU TO PHYSICAL THERAPY?

_____

EMPLOYMENT / WORK

_____ WORKING FULL-TIME _____ WORKING PART-TIME

___ HOMEMAKER ___ STUDENT ___ RETIRED ___ UNEMPLOYED

OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

LIVING ENVIRONMENT

DO YOU LIVE ALONE: ___YES ___NO

IS SOMEONE AVAILABLE TO HELP YOU WITH YOUR DAILY ACTIVITES: ___YES ___NO

ARE YOU HELPING SOMEONE ELSE WITH THEIR DAILY ACTIVIES: ___YES ___NO

DOES YOUR HOME HAVE:

___ STAIRS ___ STAIRS, RAILING

___ UNEVEN TERRAIN

___ RAMPS DEVICES

___ ANY OBSTACLES_____

_____

DO YOU USE:

___ GLASSES ___ HEARING AIDS

___ CANE ___ WALKER OR ROLLATOR

___ MANUAL WHEELCHAIR

___ MOTORIZED WHEELCHAIR

___ OTHER _____

WHERE DO YOU LIVE:

___ PRIVATE HOME___ PRIVATE APARTMENT

___ ASSISTED LIVING /GROUP HOME

___ OTHER_____

SOCIAL / HEALTH HABITS

DO YOU CURRENTLY SMOKE TOBACCO ___YES ___ NO

DO YOU CURRENTLY USE SMOKELESS TOBACCO? ___YES ___NO

DO YOU EXERCISE BEYOND NORMAL DAILY ACTIVITIES AND CHORES?

___ YES, PLEASE DESCRIBE THE EXERCISE_____

___ NO

PAIN SCALE: BEST 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

WORST 0 –1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

CURRENT 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

HAVE YOU EVER HAD SURGERY? ___YES ___NO

If yes, please list

MONTH / YEAR

_____ _____ / _____

_____ _____ / _____

_____ _____ / _____

DO YOU HAVE A PACEMAKER? ___ YES ___ NO

PLEASE C HECK IF YOU HAVE EVER HAD:

___ ARTHRITIS ___ BROKEN BONES / FRACTURES ___ STROKE ___ OSTEOPOROSIS
___ BLOOD DISORDERS ___ CIRCULATION / VASCULAR PROBLEMS ___ HEART PROBLEMS ___ LUNG PROBLEMS
___ALLERGIES ___DIABETES HIGH BLOOD SUGAR ___ SKIN DISEASES ___ HIGH BLOOD PRESSURE
___ HEAD INJURY ___ MULTIPLE SCLEROSIS ___ SEIZURES/EPILEPSY ___ PARKINSON DISEASE
___ CANCER ___ HYPOGLYCEMIA LOW BLOOD SUGER ___ FIBROMYALGIA ___ MUSCULAR DYSTROPHY
___ DEPRESSION ___ ULCERS / STOMACH PROBLEMS ___KIDNEY PROBLEMS ___ THYROID PROBLEMS
___DEVELOPMENTAL OR GROWTH PROBLEMS ___ INFECTIOUS DISEASES (EG. TUBERCULOSIS, HEPATITIS)
___ REPEATED INFECTIONS ___OTHER:_____

WITH IN THE PAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?
(CHECK ALL THAT APPLY):

___ CHEST PAIN ___ DIFFICULTY SWALLOWING ___ DIZZINESS OR BLACKOUTS ___ WEAKNESS IN THE ARMS OR LEGS
___ COUGH ___ HEART PALPITATIONS ___ COORDINATION PROBLEMS ___ JOINT PAIN OR SWELLING
___ HOARSENESS ___ PAIN AT NIGHT ___ SHORTNESS OF BREATH ___ FEVER / CHILLS / SWEATS
___ HEADACHES ___ LOSS OF BALANCE ___ DIFFICULTY WALKING ___ DIFFICULTY SLEEPING
___ BOWEL PROBLEMS ___ WEIGHT LOSS / GAIN ___ VISION PROBLEMS
___ URINARY PROBLEMS ___ HEARING PROBLEMS ___ OTHER:_____

CURRENT CONDITIONS(S)/CHIEF COMPLAINT(S)

DESCRIBE THE PROBLEM(S) FOR WHICH YOU SEEK PHYSICAL THERAPY:_____
_____
WHEN DID THE PROBLEM(S) BEGIN (DATE)? _____
WHAT HAPPENED THAT CAUSED THE PROBLEM?_____
DID YOU HAVE SURGERY FOR THE PROBLEM(S) ___YES ___ NO IF YES, DATE OF SURGERY: _____
HAVE YOU EVER HAD THE PROBLEM(S) BEFORE? ___ YES ___ NO
IF YES:
DID THE PROBLEM(S) GET BETTER? ___ YES ___ NO
HOW HAVE YOU BEEN TAKING CARE OF THE PROBLEM(S)? _____
_____
WHAT MAKES THE PROBLEM(S) BETTER? _____
_____
WHAT MAKES THE PROBLEM(S) WORSE? _____
_____
WHAT ARE YOU GOALS FOR PHYSICAL THERAPY? _____
_____

FUNCTIONAL STATUS/ACTIVITY LEVEL (CHECK ALL THAT APPLY):

___ DIFFICULTY WITH LOCOMOTION/MOVEMENT:
___ BED MOBILITY ___ TRANSFER (SUCH AS MOVING FROM BED TO CHAIR ETC.)
___ GAIT (WALKING)
___ ON LEVEL SURFACE ___ ON RAMPS ___ ON STAIRS ___ ON UNEVEN TERRAIN
___ DIFFICUTLY WITH SELF-CARE (SUCH AS BATHING, DRESSING, EATING, TOILETING)
___ DIFFICULTY WITH HOME MANAGEMENT (SUCH AS HOUSE HOLD CHORES, SHOPPING, DRIVING/TRANSPORTATION)
___ DIFFICUTLY WITH COMMUNITY AND WORK ACTIVITIES
___ WORK/SCHOOL
___ RECREATIONAL OR PLAY ACTIVITIES

ARE YOU SEEING ANYONE ELSE FOR THE PROBLEM(S)? (CHECK ALL THAT APPLY):

___ ACUPUNCTURIST ___ DENTIST ___ CARDIOLOGIST ___ CHIROPRACTOR ___ FAMILY PRACTITIONER ___ PRIMARY CARE PHYSICIAN
___ INTERNIST ___ NEUROLOGIST ___ MASSAGE THERAPIST ___ PEDIATRICIAN ___ OBSTERICIAN/GYNECOLOGIST ___ OCCUPATIONAL THERAPIST
___ ORTHOPAEDIST ___ OSTEOPATH ___OTHER:_____

OTHER CLINICAL TEST: WITH IN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING TEST? (CHECK ALL THAT APPLY)

___ ANGIOGRAM ___ ARTHROSCOPY ___ BIOPSY ___ BLOOD TEST ___ BONE SCAN ___ CT SCAN
___ MRI ___ STRESS TEST ___NCV (NERVE CONDUCTION VELOCITY) ___ CARDIOLOGICAL TEST ___ X-RAY
___ OTHER:_____

Orthopaedic & Sports Therapy Center

MEDICARE PRECERTIFICATION FORM

Have you had outpatient physical therapy this calendar year? YES / NO

If yes, where did you receive physical therapy?_____

What condition/part of body did you receive physical therapy on?_____

_____

HOME HEALTH INQUIRY

The following are examples of Home Health or Skilled Nursing services. If you are receiving any one of these services, you cannot receive outpatient physical therapy. Medicare **will not** pay for both services at the same time.

-Skilled Nursing	-Personal Care services
-Physical Therapy	-Wound Care
-Occupational Therapy	-Infusion Therapy
-Speech Therapy	-Social Work
-Bathing Assistance	-Respiratory services

Please initial all that apply:

_____ I **do not** have Medicare coverage.

_____ I do have Medicare coverage.

_____ I am receiving home health or skilled nursing.

When will you be discharged? _____

Name of Home Health agency _____

_____ I am **not** receiving home health or skilled nursing.

Patient Name (Print): _____ Date:_____

Signature of patient or responsible party: _____

Signature of OSTC Representative: _____

STATEMENT OF PATIENTS RIGHTS AND CONSENT TO TREAT

Thank you for choosing Orthopaedic & Sports Therapy Center for your outpatient rehabilitation needs. In order to receive the most out of your program, we want you to know the following information.

YOUR RIGHTS

You have the right to:

- Exercise these rights without regard to sex, culture, economic, educational, or religious background or the source of payments for your care.
- Considerate and respectful care at all times and under all circumstances, with the recognition of personal dignity.
- Knowledge of the name of the physical therapist who has primary responsibility for coordinating your physical therapy program and the names and professional relationships of the interdisciplinary team members who will see you.
- Receive information about your illness and the course and outcome of treatment in terms that you can understand.
- Receive as much information as you need about the program and the components that it entails in order for you to give informed consent or to refuse this course of treatment.
- Participate actively in decisions regarding your care. This includes right to treatment.
- Full consideration of privacy when attending the physical therapy program. Some of the areas are not as private as we would like them to be. Let us know if you are not comfortable discussing issues with the team members in this setting. You have the right to be advised as to the reason for the presence of an individual.
- Confidential treatment of all communications and records pertaining to your care. You will need to provide written permission before medical records can be released.
- Reasonable responses to any reasonable request you may make for service.
- Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing the care.
- Be advised of any research affecting your care. You have the right to refuse to participate in such research projects. Any experimental or research activities will require your informed consent.
- Be informed of any continuing health care requirements following your discharge from the physical therapy program.
- Examine and receive an explanation of your bill regardless of source or payment.
- Know that all patient rights apply also to the person who may have legal responsibility to make decisions regarding medical care on your behalf.
- Wear appropriate personal clothing and religious or other symbolic items, if desired, as long as they do not interfere with diagnostic procedures or treatments.
- Expect reasonable safety insofar as the physical therapy program practices and environment are concerned.
- To discuss/resolve ethical issues surrounding your care.

COMPLIMENTS/CONCERNS

- If you have a compliment regarding the physical therapy program or a specific team member, please share it with the staff and/or Director. You may also want to write a letter to the Director.
- Direct any concern or complaint regarding your treatment while in the physical therapy program to the Director.
- You have the right for a response within a timely manner.

YOUR RESPONSIBILITIES

We ask you to assist us by:

- Providing complete and accurate information regarding your medical history.
- Reporting changes in your condition to the physical therapy team members.
- Providing written consent for treatment as requested.
- Complying with your instructions and letting physical therapy staff know if you have concerns about the treatment program.
- Asking questions of the physical therapy staff and actively participating in your care.
- Being considerate of others and respecting their confidentiality and privacy. Our space is not always as private as we would prefer. Please leave the information you may overhear or see here at OSTC.
- Meeting financial responsibilities, including provision of appropriate insurance and billing information.

I have read and understand these rights and responsibilities for physical therapy. I agree to follow above stated rules and consent to initiate treatment as prescribed by my physician and Physical Therapist.

Responsible Party Signature _____ Date _____

Printed Name _____

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Name:_____ Date:_____

Please list all of the medications that you currently use, this includes prescription, over-the-counter, herbals, vitamins/minerals, and nutritional supplements. Also, include dosage, frequency, and how administered (oral/injection/other).

Medication	Dosage	Frequency	Administered