OSTC Orthopaedic & Sports Therapy Center

#1 West Medical Court
Wichita Falls, Tx. 76310

940-692-4688
940-692-8388 (FAX)
www. ostcwf.com

PATIENT INFORMATION

PATIENT NAME

FIRST: _____MIDDLE: _____LAST: _____
PREFERRED NAME: _____ DOB: _____ SSN: _____

RESPONSIBLE PARTY (IF UNDER 18)

NAME: _____ PHONE: _____
DOB: _____ SSN: _____ RELATION TO PATIENT: _____
MAILING ADDRESS: _____
_____

MAILING ADDRESS

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

PATIENT CONTACT INFORMATION

HOME PHONE: _____CELL PHONE: _____WORK PHONE: _____
EMAIL 1: _____ PREFERRED METHOD OF CONTACT: _____

EMERGENCY CONTACT

NAME: _____
PHONE: _____ RELATION: _____

INSURANCE INFORMATION

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

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

PRIVACY PRACTICE NOTIFCATION

_____ NOTICE OF PRIVACY PRACTICES

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.

_____ 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.

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_____

Insurance Assignment/Financial Responsibility

PLEASE READ, INITIAL, AND SIGN BELOW

_____ 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.

Patient
Name(PRINT)_____Signature_____Date_____

Responsible Party
Name (PRINT)_____Signature_____

MEDICAL HISTORY INFORMATION

NAME:

_____ _____ _____ _____ _____

LAST FIRST MI JR/SR DOB

GENDER: _____ MALE _____ FEMALE

WHO IS YOUR PRIMARY DOCTOR? _____

WHO REFERRED YOU TO PHYSICAL THERAPY?

_____

LANGUAGE: ___ ENGLISH UNDERSTOOD

*INTERPRETER NEEDED: Yes / No (circle one)

DOMINANT HAND: _____ RIGHT _____ LEFT (CIRCLE ONE)

IF YOU ARE A STUDENT

SCHOOL ATTENDING: _____

DO YOU PLAY SPORTS? Yes / No (circle one)

WHAT SPORT(S)? _____

EDUCATION: HIGHEST GRADE COMPLETED

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

EMPLOYMENT / WORK

____ FULL TIME ____ PART TIME ____ UNEMPLOYED

____ HOMEMAKER ____ STUDENT ____ RETIRED

OCUPATION: _____

PLACE OF EMPLOYMENT: _____

LIVING ENVIRONMENT

DO YOU LIVE ALONE: ___ YES ___ NO

IS SOMEONE AVAILABLE TO HELP YOU WITH YOUR DAILY ACTIVITIES: ___ YES ___ NO

ARE YOU HELPING SOMEONE ELSE WITH THEIR DAILY ACTIVITIES: ___ YES ___ NO

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 ___ NO

IF YES, PLEASE DESCRIBE THE EXERCISE _____

PAIN SCALE:

HOW YOU'VE FELT IN THE PAST COUPLE OF WEEKS

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

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

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

0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

HAVE YOU EVER HAD SURGERY? ___ YES ___ NO

IF YES, PLEASE LIST MONTH / YEAR

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU HAVE A PACEMAKER?

___ YES ___ NO

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

___ PRIMARY CARE PHYSICIAN ___ MASSAGE THERAPIST ___ ACUPUNCTURIST ___ CARDIOLOGIST

___ CHIROPRACTOR ___ OCCUPATIONAL THERAPIST ___ FAMILY PRACTIONER ___ NEUROLOGIST

___ MASSAGE THERAPIST ___ PEDIATRICIAN ___ ORTHOPAEDIST

___ OTHER: _____

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

___ ANGIOGRAM ___ BIOPSY ___ BLOOD TEST ___ BONE SCAN ___ CT SCAN ___MRI
___ STRESS TEST ___ X-RAY ___ CARDIOLOGY TEST ___ NCV (NERVE CONDUCTION VELOCITY)
___ OTHER: _____

PLEASE CHECK IF YOU HAVE EVER HAD

___ ARTHRITIS ___ BROKEN BONES / FRACTURES ___ STROKE ___ OSTEOPOROSIS
___ BLOOD DISORDERS ___ CIRCULATION / VASCULAR PROBLEMS ___ HEART PROBLEMS ___ ALLERGIES
___ LUNG PROBLEMS ___ DIABETES HIGH BLOOD SUGAR ___ HIGH BLOOD PRESSURE
___ SKIN DISEASE ___ MULTIPLE SCLEROSIS ___ PARKINSON DISEASE ___ CANCER
___ HEAD INJURY ___ SEIZURES / EPILEPSY ___ FIBROMYALGIA
___ KIDNEY PROBLEMS ___ THYROID PROBLEMS ___ THYROID PROBLEMS ___ REPEATED INFECTIONS
___ DEVELOPMENTAL OR GROWTH PROBLEMS ___ INFECTIOUS DISEASE (EF. TUBERCULOSIS, HEPATITIS)
___ HYPOGLYCEMIA LOW BLOOD SUGER
___ DEPRESSION *IF YES, ARE YOU TREATED FOR DEPRESSION? ___ YES ___ NO
___ OTHER: _____

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

___ CHEST PAIN ___ DIZZINESS OR BLACKOUTS ___ FEVER / CHILLS/ SWEATS ___ LOSS OF BALANCE
___ HEART PALPITATIONS ___ COORDINATION PROBLEMS ___ SHORTNESS OF BREATH ___ PAIN AT NIGHT
___ DIFFICULTY SLEEPING ___ BOWEL PROBLEMS ___ WEIGHT LOSS / GAIN ___ VISION PROBLEMS
___ URINARY PROBLEMS ___ OTHER: _____

CURRENT CONDITION(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 YOUR GOALS FOR PHYSICAL THERAPY?

_____
_____

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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
-Physical Therapy
-Occupational Therapy
-Speech Therapy
-Bathing Assistance
-Personal Care services
-Wound Care
-Infusion Therapy
-Social Work
-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: _____

LEGAL CASES

Is your current medical condition for which you are seeking physical therapy involved with a past or present legal case? (Please circle one)

YES / NO

If yes please list your attending law office and lawyers 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, please include dosage, frequency, and how administered. If you are not currently taking any medications, please check mark the “no medications taken” box below.

☐ **NO MEDICATIONS TAKEN**

Please be sure to fill out ALL columns

Medication	**Dosage**	**How Much**	**How Often/ When**						**Administered**		
			Daily	*Morning*	*Afternoon*	*Evening*	*Bedtime*	*As Needed*	*Oral*	*Injection*	*Other*
Example: Gabapentin	*300mg*	*2 pills*	☑	☐	☐	☐	☐	☐	☑	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐
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*****Per Medicare Guidelines: All Medicare patients are required fill out medication list*****

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 _____

APPOINTMENT REMINDERS

We are excited to announce we have implemented new technology for automated appointment reminders. It is important for you to reply to the reminders to let us know if you intend to keep your appointment, since we have patients on a waitlist who can fill open slots.

In addition, after your appointment with your therapist, you may receive a short email or text message survey. We value your feedback and would appreciate you taking time to complete the survey so we can continue to provide the best care and experience for all of our patients.

Please fill out your contact information:

Patient: _____
Responsible Party (if different from patient) _____
Home Phone: _____
Cell phone: _____
Email: _____
Circle one: English / Spanish / Other: _____

Please check which reminder type(s) you would prefer to be contacted at for your appointment reminders:

- ☐ Voice Call
- ☐ Text Message
- ☐ Email
- ☐ No Reminders

Note: Please keep in mind that this system could also alert the above selected reminder type if there is a time where we have to close, open early, or open late for any reason (Example: bad weather). If you choose to not have a reminder alert, please be aware that you may not receive any emergency notifications.

I give permission to the staff at Orthopaedic and Sports Therapy Center to communicate personal health information electronically.

- ☐ Yes
- ☐ No

Signature _____ Date _____