Welcome to Orthopedic Spine and Sports Therapy!

On behalf of the entire staff, we would like to welcome you to our clinic. We are pleased to have the opportunity to assist you with your physical therapy care. Our goal is to provide the highest quality and most up-to-date physical therapy treatments available in a professional and caring manner. We are committed to helping you attain your rehabilitation goals while striving to meet our philosophy and principles and provide you with outstanding service.

We would like to review a few of the office policies with you. We believe this will improve your understanding of how our office works and will enable you to receive the maximum benefit from the physical therapy treatments you will receive.

Our office policies are as follows:

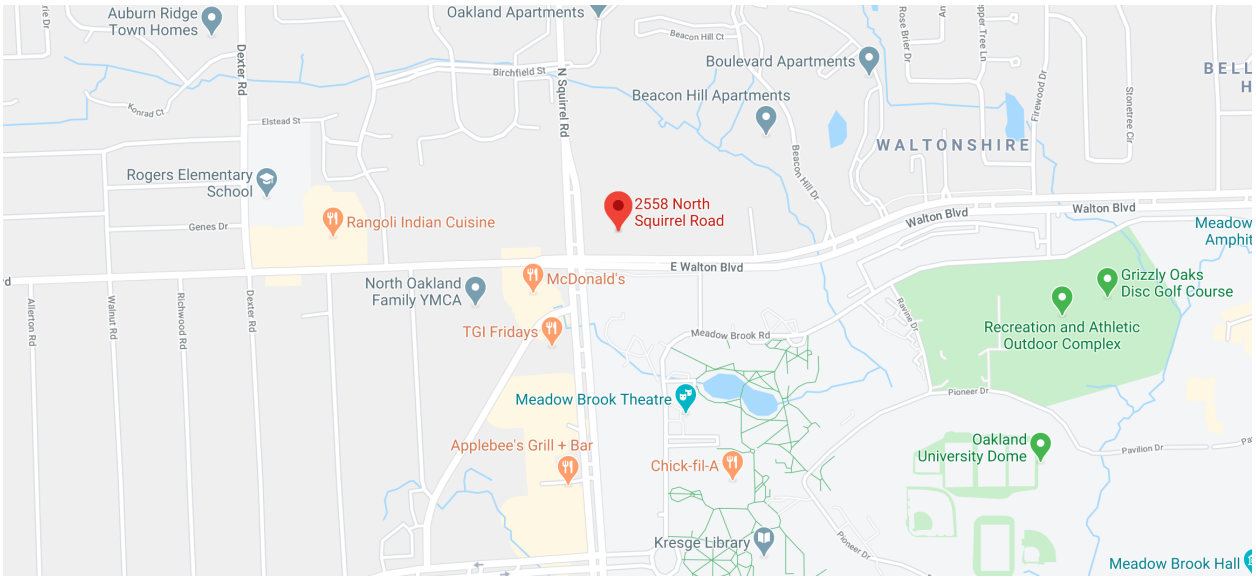
- Your appointment time begins at the time noted on the appointment card. Our goal is to keep your waiting time, if at all, to less than five minutes. Each treatment session will compose of at least 25-30 minutes of hands-on manual therapy provided by the same therapist each treatment session.
- Should you arrive past your appointment time, we will do everything we can to ensure you receive the maximum benefit from your program. Please understand our commitment to outstanding service extends to all of our clients.
- We will call and verify your insurance benefits as a courtesy to you. You should, however, be aware of any limitations or stipulations your insurance may have regarding physical therapy care. We are not responsible for inaccurate or mistaken information from the insurance company regarding your benefits.
- We will provide your doctor with a report of your progress at the time of your follow up visit with him/her. Please notify us of your follow up appointment and any appointment changes that may occur so that we can prepare your report accordingly.

Whether you seek to resume pain free activities at home, work, or play, we are confident you will find your experience at the office to be valuable in helping you reach your goals.

Thank you for choosing Orthopedic Spine and Sports Therapy. Should you have any questions or comments, please do not hesitate to contact us.

Auburn Hills Location
2558 N. Squirrel Rd, Auburn Hills
(248) 340-1100
Fax: (248) 340-1101

Troy Location
5551 Crooks Rd, Troy
(248) 970-0000
Fax: (248) 970-1010



AUBURN HILLS Our Auburn Hills location is located at the North East corner of Squirrel Rd. and Walton Rd. sharing a plaza with Buddy's Pizza.

TROY Our Troy location is located on the West side of Crooks Rd. between Square Lake Rd. and Long Lake Rd. across from the I-75 exit. We are located next to Panera Bread and share a plaza with Starbucks Coffee.

ORTHOPEDIC SPINE & SPORTS THERAPY

Physical Therapy Patient Health History

Name: _____ Date: _____

Date of birth: _____ Height: _____ Weight: _____ BMI (office staff will calculate): _____

Reasons for seeking physical therapy

How did you hear about this clinic? _____

What is the reason for your visit to physical therapy? _____

When did this problem begin? _____ Has a doctor examined you for this problem? ☐ Yes ☐ No

Is this visit related to an auto accident or worker's compensation? ☐ Auto ☐ Worker's Comp ☐ No

Have you had surgery for this problem? ☐ Yes ☐ No If yes, when? _____

What type of surgery? _____

List any activities/ movements your doctor asked you to avoid: _____

List any recent diagnostic testing (MRI ,X-Rays, blood tests, etc): _____

_____

List all medications (prescription and over-the-counter) that you are currently taking: _____

_____

2. General Health History: Please check or list all current and past medical conditions

Currently pregnant	☐ yes	☐ no	Stroke	☐ yes	☐ no	Frequent infections	☐ yes	☐ no
Cancer	☐ yes	☐ no	Headaches/Migraines	☐ yes	☐ no	Falls/loss of balance	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Epilepsy	☐ yes	☐ no	Loss of bladder control	☐ yes	☐ no
Heart disease	☐ yes	☐ no	Breathing difficulty	☐ yes	☐ no	Loss of bowel control	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	COPD	☐ yes	☐ no	Osteoarthritis	☐ yes	☐ no
High blood pressure	☐ yes	☐ no	Asthma	☐ yes	☐ no	Rheumatoid Arthritis	☐ yes	☐ no
Circulatory problems	☐ yes	☐ no	Intestinal disorders	☐ yes	☐ no	Metal Implants	☐ yes	☐ no
Bleeding problems	☐ yes	☐ no	Liver problems	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Clotting problems	☐ yes	☐ no	Gallbladder problems	☐ yes	☐ no	Gout	☐ yes	☐ no

List health conditions not listed above:_____

_____

List all surgeries and approximate dates: _____

_____

Authorizations & Releases

Date_____ **Name**_____

The undersigned acknowledges that he or she personally has the ability to review and/or receive a copy of the Notice of Privacy Practices for ***Orthopedic Spine & Sports Therapy***.

I, the undersigned, hereby authorize and instruct my insurance company, adjuster, rehabilitation representative, attorney, social worker, employer, any other payer, or myself to pay any and all benefits/monies directly to ***Orthopedic Spine & Sports Therapy*** for any services rendered to me due to accident or illness. In addition, ***I fully understand I am responsible for any amount not covered by my insurance.*** I acknowledge that my insurance policy may have a copay requirement which I understand I am responsible to pay at the time services are rendered.

I, the undersigned, hereby authorize ***Orthopedic Spine & Sports Therapy*** to release any and all information relevant to and pertaining to my care and treatment to my physicians, adjuster, social worker, attorney, or rehabilitation representative. Furthermore, I authorize ***Orthopedic Spine & Sports Therapy*** to release any and all information to my insurance companies required pursuant to the processing of my claims.

I, the undersigned, hereby consent to and authorize ***Orthopedic Spine & Sports Therapy, Physical Therapy*** to administer physical therapy treatment to me for which I am responsible. I have been informed by my physician as to the nature and the purposes for which physical therapy is to be performed and administered by ***Orthopedic Spine & Sports Therapy***. However, I do acknowledge there may be additional procedures as deemed necessary on the basis of findings during the course of said physical therapy treatment. I consent to such procedures after an explanation has been given of their nature and purpose. In addition, I acknowledge results are contingent on my participation in my treatment, though are still not guaranteed.

By signing this document, I agree, in order for ***Orthopedic Spine & Sports Therapy*** to service my account or to collect any amounts I may owe, ***Orthopedic Spine & Sports Therapy*** and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I authorize contact from this office to confirm my appointments, treatment, billing information, special services and information about my health via phone, text and/or email:

- Cell phone: _____
- Email Address: _____

☐ If you do not wish to receive Orthopedic Spine and Sports brand or organizational marketing, please check the following box.

We have read this disclosure and authorize express consent that Orthopedic Spine & Sports Therapy, its affiliates, and third party service providers may contact me/us as described above.

Please list any other parties who can have access to your health information, as well as an emergency contact person, in case of an emergency while you are at our clinic. Please provide a phone number for the emergency contact.

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

I certify all information given on my intake forms is accurate. A photocopy of this authorization shall be acceptable as the original. I certify that I have read and fully understand the above consents.

_____ _____

Please print your name Please sign your name

_____ _____

OSST Witness Signature Date

List food and drug allergies: _____

_____

_____

Other known allergies: _____

On average, how many days per week do you exercise? _____

Do you currently smoke? ☐ yes ☐ no Number of years smoking: _____ Number of packs per day: _____

On average, how many alcoholic drinks do you consume per week? _____

3. Pain Assessment

Do you have pain? ☐ Yes ☐ No (If no, please skip to section 4)

Circle the percent of day you have pain? 0-25; 26-50; 51-75; 76-100

On a scale of 0-10, what is your pain intensity? Average: ___ Worst: ___ Best: ___

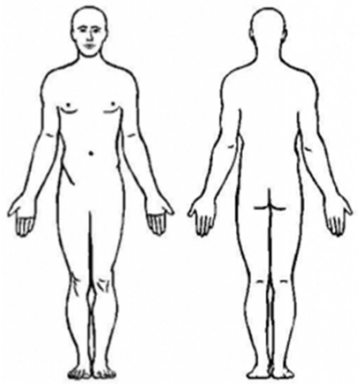
How long has this pain been present? _____

Since your pain began, is it getting: ☐ better ☐ worse ☐ the same

Have you had the same or similar pain before? ☐ Yes ☐ No If yes, when?

_____

Briefly list any treatment you have received for this condition (medication, therapy, chiropractic,etc):_____



Indicate the location (s) of the pain you are seeking PT for.

4. Function Assessment: Answer the following questions regarding the symptoms for which you are seeking

Hand dominance ☐ right ☐ left	
Do your symptoms make it more difficult to:	
…sleep through the night? ☐ yes ☐ no	…care for yourself (dressing, bathing, eating)? ☐ yes ☐ no
…move around inside your home? ☐ yes ☐ no	…care for others who depend on you? ☐ yes ☐ no
…participate in social, fitness activities? ☐ yes ☐ no	…carry out normal job or household activities? ☐ yes ☐ no
…perform other activities not listed? ☐ yes ☐ no	
Fall screening: Which of the following applies to you?	
I have had 2 or more falls, or 1 fall with an injury in the past year. ☐ yes ☐ no	
I have had 1 fall without injury. ☐ yes ☐ no	
I have not fallen in the past year. ☐ yes ☐ no	

Please be advised that if you wish to review the NOTICE OF PRIVACY PRACTICES a copy will be provided for you.

Therapist Notes:

Patient Signature: _____

Name (Printed)_____

Policy and Procedure
HIPAA/PRIVACY
Acknowledgement of Receipt of Notice of Privacy Practices

Patient's Name: _____

Address:_____

Facility Name:_____

I have been given a copy of Orthopedic Spine and Sports Therapy in Auburn Hills' Notice of *Privacy Practices ("Notice"),* which describes how my health information is used and shared. I understand that Orthopedic Spine and Sports Therapy in Auburn Hills has the right to change THIS Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g. Guardian, Executor of Estate, Health Care Power of Attorney)

I allow the following person(s) to have access to my documented medical records:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____
_____

2. Describe the steps taken to obtain the patient's (or personal representatives) signature on the Acknowledgement:

_____
_____

Completed by: _____

_____ _____
Signature of Facility Representative Date

_____
Print Name