OSP
ORTHOPAEDIC & SPORT PHYSIOTHERAPY

NEW PATIENT FORM

LAST NAME: _____ FIRST NAME:_____ M.I:_____

ADDRESS:_____
STREET CITY STATE ZIP CODE

PHONE:_____(☐ Cell or ☐ House) EMAIL:_____

D.O.B:_____/_____/_____ ☐ MALE ☐ FEMALE REFERRING PHYSICIAN: _____

☐ For SELF PAY, just check box

PRIMARY HEALTH INSURANCE

INSURANCE NAME: _____ ID#: _____

GROUP #: _____ SUBSCRIBER NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ RELATIONSHIP: _____

SUBSCRIBER ADDRESS IF DIFFERENT: _____
STREET CITY STATE ZIP CODE

SECONDARY HEALTH INSURANCE

INSURANCE NAME: _____ ID#: _____

GROUP #: _____ SUBSCRIBER NAME: _____

SUBSCRIBER D.O.B: _____/_____/_____ RELATIONSHIP: _____

SUBSCRIBER ADDRESS IF DIFFERENT: _____
STREET CITY STATE ZIP CODE

ACCIDENT INFORMATION

CLAIM NUMBER: _____ ADJUSTER NAME: _____

INSURANCE NAME: _____ INSURANCE PHONE: _____

CLAIM MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

FOR OFFICE USE ONLY

Body region: ☐ C/S ☐ T/S ☐ L/S ☐ Shoulder ☐ Elbow ☐ Wrist/hand ☐ Hip ☐ Knee ☐ Ankle ☐ TMJ ☐ Balance

ICD-10 Codes:_____ **Template:** ☐ Ex2 ☐ Ex ExN ☐ Ex 4 ☐ Other:_____ ☐ GP

Referred by: Physician: _____ **Patient:** _____

Current patient is former patient of: ☐ Sean ☐ Glynn ☐ Other:_____ ☐ Online ☐ Insurance ☐ McKenzie website

Authorization required? ☐ YES ☐ NO **Today's charges:** ☑ IE ☐ Ex2 ☐ Ex ExN ☐ Other:_____

Deductible? ☐ YES: $_____ ☐ NO

Copay? ☐ YES: $_____ ☐ NO

Special IE modifiers needed? ☐ YES: ☐ GP ☐ 59
(only click box if YES)

☐ Note DONE

☐ Submitted

☐ Self pay IE ☐ Preventative screen

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MEDICAL HISTORY

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Please describe, in your own words, the reason that prompted you to see physical therapy. And please your goals/expectations also.

_____

_____

Have you recently experienced any of the following symptoms: ☐ **Dizziness** ☐ **Lightheadedness** ☐ **Visual changes** ☐ **Speech changes**

☐ **Swallowing issues** ☐ **Headaches** ☐ **Nausea/Vomitting** ☐ **Bowel/bladder changes** ☐ **Balance issues/falls** ☐ **Clumsiness/ dropping things**

☐ **Arm/hand weakness** ☐ **Leg/foot weakness** ☐ **Numbness/tingling** ☐ **Chest pain** ☐ **Fever, ill, or unwell**

PLEASE CHECK THOSE THAT APPLY

☐ Heart Condition	☐ Stroke	☐ Seizures	☐ Cancer	☐ Diabetes	☐ High Cholesterol
☐ Kidney Disease	☐ Hepatitis	☐ COPD	☐ Osteoporosis	☐ Wgt Loss/Gain	☐ High Blood Pressure
☐ Dizziness	☐ Surgery	☐ Hospitalized	☐ Pregnant	☐ Allergies	☐ Other Illness/injury

PLEASE BRIEFLY EXPLAIN ANY CHECKS ABOVE

_____

_____

Have you had any other treatment for this in the past year? _____

When did your symptoms start? _____ **How did they begin?** _____

What activities/movement/positions make you symptoms better or worse?

Worse: _____

Better: _____

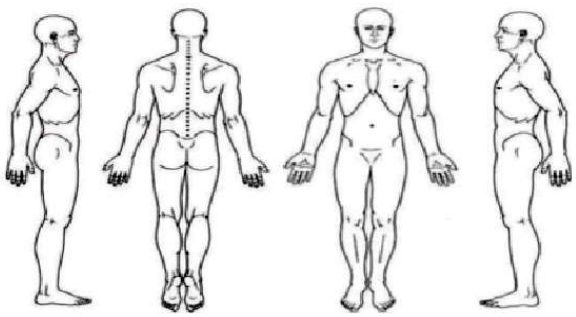
How often do you experience your symptoms? ☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

Describe the nature of your symptoms. ☐ Dull Ache ☐ Shooting ☐ Sharp ☐ Burning ☐ Numb ☐ Tingling

PLEASE RATE YOUR PAIN LEVELS

	None										Unbearable
At Best	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
At Worst	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Current	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Please indicate where you have pain and/or other symptoms



_____ _____

Patient Signature Date

NOTICES OF PRIVACY PRACTICES

A federal regulation, known as the "HIPAA Privacy Rule", requires that we provide detailed notice in writing of our privacy practices. This describes how medical information about you may be used and disclosed. (HIPAA – Health Insurance Portability and Accountability Act)

If you have any questions about this Notice please contact our office staff.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your therapist to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your therapist will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the therapist's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the therapist's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician from whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physical therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physical therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints

Complaints about your Privacy rights, or how we have handled your health information should be directed to Glynn Hunt, PT, DPT, MS by calling this office. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of

I have read the Privacy Notice and understand my rights contained in the notice.

By the way of my signature, I provide OSP with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____
Patient's Name (PRINT)

_____ _____
Patient's Signature Date

ORTHOPAEDIC & SPORT PHYSIOTHERAPY

Policies & Procedures

Financial Agreement

I understand that OSP will verify all information with my health insurance carrier to the best of their ability, but it is my responsibility to check with my insurance company concerning co-pays, deductibles and services.

OSP cannot guarantee that an insurance company will pay for your care, even when it is preauthorized. OSP will submit bills to your insurance carrier. This courtesy will commence as soon as we are able to confirm coverage for physical therapy services and have the proper, signed insurance forms. We strongly urge you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us.

I hereby authorize insurance benefits to be paid directly to OSP. I understand that I will be financially responsible for any non-covered services and any remaining balance. I also understand that if I terminate my care and treatment my balance will be immediately due and payable. Payment plans are at the sole discretion of OSP and prior arrangements must be made before services are rendered.

Patients who are uninsured or whose insurance does not cover physical therapy because of high deductibles or other limitations are personally responsible for payment. Payments may be paid at the time of service or on the last visit of the week.

I understand that co-payment is due at the time of service. Co-payment cannot be waived. Any problems must be addressed before your visit.

Consent to Treat

I hereby authorize OSP, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. No guarantee of your reaction to treatment, nor resolution of your condition is given. It is your right to decline any part of your treatment at any time before or during treatment.

Cancellation Policy

I understand that a $20.00 fee will be assessed for each appointment that I schedule but do not attend, or that is rescheduled with less than 24 hour advance notice. OSP reserves the right to waive such fees as a courtesy in the event of severe weather, health emergencies and special circumstance. This fee is not reimbursable by your insurance carrier.

Authorization for Medical Information Release

I authorize OSP to furnish my insurance company with medical information they may request regarding my condition or treatment. Furthermore, I authorize my referring healthcare provider to release any diagnostic reports and/or surgery reports to OSP.

I certify that I have read and understood the above policies and financial obligations. I agree to be responsible for payment of all services rendered on my behalf or my dependents according to the above terms.

Your signature is necessary before any treatment or advice is rendered.

I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Printed Name of Patient _____ **Date**_____

Signature of Patient and/or Legal Guardian_____

OSP
ORTHOPAEDIC & SPORT PHYSIOTHERAPY

Patient & Parent Waiver

Waiver: In signing this waiver below, I release OSP, LLC d.b.a. Orthopaedic & Sport Physiotherapy (hereafter referred to as "OSP"), and all of their agents, employees, independent contractors, and members from any claims or responsibility for injuries suffered in any activities or events conducted by OSP, whether occurring within or outside of the facility. I knowingly assume all risks associated with participation, even if arising from negligence of the patients or others, and assume full responsibility for my (or my child's) participation today and on all future dates.

Assumption of inherent risks: I, the adult patient, or minor patient and parent(s)/guardian(s) (hereafter referred to as patient/parent), understand that all activities of OSP include inherent risks that cannot be totally eliminated regardless of the care taken by OSP. I, the patient/parent know, understand, and appreciate the types of injuries inherent in OSP's activities, and hereby knowingly assume all inherent risks of the activities.

Indemnification: I, the patient/parent, also agree to hold harmless, defend, and indemnify from any and all claims arising from my or my child's participation in treatment.

Clarifying Clauses: I, the patient/parent, understand the foregoing assumption of risk, waiver of liability, and indemnification agreement is intended to be as broad and inclusive as permitted by the laws of the State of Pennsylvania, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect, and if legal action is brought, the appropriate trial court for the County of Bucks, in the State of Pennsylvania has the sole and exclusive jurisdiction and that only the substantive laws of the State of Pennsylvania shall apply.

Acknowledgement and Understanding: I, the patient/parent, have read and understand this agreement. I understand that I am giving up the right of the patient/child to sue for damages in the event of death, injury, or loss. I acknowledge that I am voluntarily signing the agreement, and intend my signature to be a complete release of all liability to the greatest extent allowed by the laws of the State of Pennsylvania.

_____	_____	_____
(Patient Name)	**(Patient Signature)**	**(Date)**

If patient is a minor, parent/guardian must sign below:

_____	_____	_____
(Parent/Guardian Name)	**(Parent/Guardian Signature)**	**(Date)**