Memorial Orthopaedic Physical Therapy Screening/Confidential Medical History

Patient Name: _____ Age: _____ Date: _____

Please complete the following questions to the best of your ability.
This will help us to develop a treatment with you that meets your individual needs.

1. Date of injury or when the problem last caused you to seek medical attention: _____
2. How did your current problem begin? ☐ Lifting ☐ Twisting ☐ Falling ☐ Motor Vehicle Accident ☐ Unknown ☐ Other: _____
3. Were you hospitalized for this problem? ☐ YES ☐ NO **If yes, give dates: _____**
4. Are you currently being seen by any of the following? ☐ Chiropractor ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Psychiatrist/Psychologist

   If you are seeing any of the above, please describe the reason: _____
5. **Medicare Patients:** Have you had physical, occupational or speech therapy any time this year? ☐ YES ☐ NO

   If you answered yes, where? _____
6. Are you presently working? ☐ YES ☐ NO Occupation? _____
7. Are you ☐ **right** or ☐ **left** handed?
8. Do you use a: ☐ Cane ☐ Walker ☐ None ☐ Other: _____
9. What type of exercise are you currently doing? _____
10. Do you currently experience any of the following:

☐ Cardiac Problems	☐ Rheumatoid Arthritis	☐ Multiple Sclerosis
☐ Orthopaedic Problems	☐ Seizures	☐ Drug/Alcohol Dependency
☐ Cancer	☐ Depression	☐ Diabetes
☐ Fibromyalgia	☐ Hypertension	☐ GI Problems

11. Have you ever had a broken bone or fracture? ☐ YES ☐ NO

    If yes, which body part and when? _____
12. Do you smoke? ☐ YES ☐ NO **If yes, how many packs a day?** _____
13. Are you pregnant? ☐ YES ☐ NO
14. How would you describe your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
15. List any **allergies** to medications: _____
16. If you have **not** provided this already, please list all prescription or over-the-counter medications you are currently taking: _____

    _____
17. Rate your pain using the following score, with 0 being no pain and 10 being very severe pain (please circle):

    During Rest: 0 1 2 3 4 5 6 7 8 9 10

    During Activity: 0 1 2 3 4 5 6 7 8 9 10
18. Current living situation: ☐ Living Alone ☐ Live with Spouse/Family ☐ Live in Assisted Living
19. What are your goals of therapy? _____

PHYSICAL THERAPY SIGN-IN SHEET

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's First name	Middle Init.	Last Name	Social Security Number

Address: Street	City	Zip	Home #: ( ) Cell #: ( )

Driver's License No.	Marital status (circle one) Single/ Married / Divorced /Widower	Birth date: / /	Age:	Sex: ❑ M ❑ F

Occupation:	Employer Name:	Employer Telephone: ( )

SPOUSE/OR RESPONSIBLE PARENT

First name	Middle Init.	Last Name	Social Security Number

Address: Street	City	Zip	Telephone: ( )

Driver's License No.	Occupation:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Employer Name:	Employer Telephone: ( )

IN CASE OF EMERGENCY

(Other than husband or wife) – Person not living with you

Name:	Relationship:	Telephone: ( )

Address:

PLEASE COMPLETE IF PATIENT IS UNDER 21 YEARS OF AGE OR A STUDENT

Father's Name	Mother's Name
Father's Occupation	Mother's Occupation
Father's Employer	Mother's Employer
Address	Address

INSURANCE INFORMATION

(To Be Completed In All Cases)

Primary Insurance Subscriber	Insurance Co.	Group Number:	Identification Number:

Billing Address:

Secondary Insurance Subscriber	Insurance Co.	Group Number:	Identification Number:

Billing Address:

IF INJURY

When and how did it happen? ❑Home ❑ Work ❑ Automobile ❑ Other Date_____ Hour_____Last Worked_____

Industrial Insurance Carrier:
Name & Address_____ Claim Number_____

Referred to this office by (please include address and telephone number of referring doctor)

Is patient bringing outside x-rays?_____ From?_____

AUTHORIZATION:

The undersigned patient, or authorized individual acting on behalf of the patient understands and agrees as follows:

1. James Gilmer, Lisa McWhorter, Jason Smith, Louie Labial, Michelle Schwier, Mia Nguyen and Eric Neal reserve the right to designate any qualified physical therapist to perform and administer care and treatment of the patient.
2. James Gilmer, Lisa McWhorter, Jason Smith, Louie Labial, Michelle Schwier, Mia Nguyen and Eric Neal are granted permission to release to the insurance carrier, employer their representatives or referring physician, any information in connection with any treatment rendered to patient, or in patient's behalf at any time such information is requested.
3. Patient shall pay to Orthopaedic Physical Therapy such sums as are or may become due for services rendered to the patient, it being understood that in the event patient's insurance company, if there be any, does not make payment, or only a partial payment, this obligation shall be binding personally upon patient.
4. I authorize payment of medical benefits to the doctors rendering services.

Patient/Guardian signature *Date*

PATIENT CONSENT FORM

Memorial Orthopaedic Surgical Group

Physical Therapy Department

2760 Atlantic Avenue

Long Beach, CA 90806

(562) 424-6666

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request, your organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are required to agree to my request, and by agreeing to such request, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

MEMORIAL ORTHOPAEDIC PHYSICAL THERAPY

OFFICE FINANCIAL POLICY

Thank you for choosing Memorial Orthopaedic Surgical Group. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read, agree to, and sign, prior to any treatment. This financial policy applies to all services rendered by the physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met, and any co-pay amount due, at the time services are rendered. For patients with dual insurance coverage, we will bill both primary and secondary insurance if you have provided us with necessary information.

Patients insured with plans which we **ARE NOT** contracted with will be required to pay for the first visit in full. For any follow up visits, you will need to pay 20% at the time services are rendered.

If you are insured with a plan which are **ARE** contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductibles, and your co-pay amount, at the time of each visit.

Patients with no insurance coverage are required to pay for services at the time services are rendered.

Our acceptance methods of payments are Cash, Visa, MasterCard or Discover Card.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all the proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating with physical therapists outside of the designed network or if the proper authorization has not been obtained.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our billing/insurance department.

I have read, understood, and agree to the provisions of this policy.

_____ Date: _____

Patient/Guarantor Signature

_____ Date: _____

Print Name

Memorial Orthopaedic Surgical Group: Physical Therapy Department

Memorial Orthopaedic Surgical Group

MRN: _____

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

Please check all boxes that you give Memorial Orthopaedic Surgical Group permission to use for your communications:

□ You may contact me by telephone Phone Number:_____ □ You may leave a message/voice mail Phone Number:_____
□ You may contact me by mail
□ You may contact me through email (Mychart)

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		□ Billing Information □ Appointment Information □ Medical/Health Information
2.		□ Billing Information □ Appointment Information □ Medical/Health Information
3.		□ Billing Information □ Appointment Information □ Medical/Health Information
4.		□ Billing Information □ Appointment Information □ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient