



DATE: _____ NAME: _____

DOB: _____ Email: _____

DEMOGRAPHIC INFORMATION

WHERE DO YOU LIVE?

- PRIVATE HOME OR APT.
- ASSISTED LIVING OR GROUP HOME
- LONG-TERM CARE FACILITY
- OTHER _____

WHO DO YOU LIVE WITH? (CHECK ALL THAT APPLY)

- ALONE
- SPOUSE/SIGNIFICANT OTHER
- CHILD/CHILDREN
- GROUP SETTING
- PERSONAL CARE ATTENDANT
- OTHER _____

DOES YOUR OCCUPATION PRIMARILY INVOLVE?

EMPLOYMENT/WORK STATUS (CHECK ALL THAT APPLY)

- | | | |
|--|--|--|
| <input type="checkbox"/> SITTING AT A COMPUTER OR PROLONGED COMPUTER USE | <input type="checkbox"/> FULL-TIME, OUTSIDE HOME | <input type="checkbox"/> FULL-TIME, IN HOME |
| <input type="checkbox"/> MANUAL LABOR | <input type="checkbox"/> RETIRED | <input type="checkbox"/> PART-TIME, OUTSIDE HOME |
| <input type="checkbox"/> HOMEMAKER | <input type="checkbox"/> OTHER | <input type="checkbox"/> WORKING WITH MODIFICATION BECAUSE OF CURRENT INJURY |
| <input type="checkbox"/> HOMEMAKER WITH SMALL CHILDREN | | <input type="checkbox"/> NOT WORKING BECAUSE OF CURRENT ILLNESS/INJURY |
| | <input type="checkbox"/> UNEMPLOYED | <input type="checkbox"/> RETIRED |
| | <input type="checkbox"/> OTHER _____ | |

WHAT ARE YOUR HOBBIES AND ARE YOU ABLE TO CURRENTLY PARTICIPATE AT THE LEVEL AND FREQUENCY YOU WOULD LIKE?

PAST MEDICAL HISTORY

LIST ALL HEALTH PROBLEMS, HOSPITALIZATIONS, SURGERIES AND ALLERGIES OR PROVIDE A LIST TO YOUR THERAPIST:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR PROVIDE A LIST TO YOUR THERAPIST:

ARE YOU A DIABETIC? YES NO DO YOU HAVE A PACEMAKER? YES NO
IF YES, FOR HOW LONG? _____

ARE YOU PREGNANT? YES NO
IF YES, HOW MANY MONTHS? _____

DO YOU USE A? (CHECK ALL THAT APPLY)

- CANE
- WALKER/ROLLING WALKER/ROLLATOR
- MANUAL WHEELCHAIR
- MOTORIZED WHEELCHAIR
- OTHER _____

If yes to any of the above, what condition necessitates the use of assistance? _____

PLEASE LIST OTHER PHYSICIANS WHO ARE TREATING YOU AND FOR WHAT CONDITION
(DO NOT INCLUDE THE CONDITION YOU ARE HERE FOR)

HAVE YOU RECEIVED PREVIOUS PHYSICAL OR OCCUPATIONAL THERAPY? YES NO
If yes, for what condition and what did you like/dislike about the treatment?

DO YOU CURRENTLY HAVE A FAMILY PHYSICAL THERAPIST? YES NO

IN GENERAL, HOW WOULD YOU SAY YOUR OVERALL HEALTH IS RIGHT NOW?

- EXCELLENT
- GOOD
- FAIR
- POOR



**QUESTIONS 1-9 ARE FOR PATIENTS WHO ARE HERE AS A
RESULT OF AN INJURY, CONDITION, OR FOR A PRE-HAB VISIT (NON-SURGICAL)**

- 1 DESCRIBE YOUR CURRENT SYMPTOMS: _____

- 2 DID YOUR SYMPTOMS BEGIN AS A RESULT OF A SPECIFIC INJURY OR GRADUAL ONSET?
 INJURY GRADUAL ONSET EXPLAIN: _____
- 3 HOW OFTEN ARE SYMPTOMS EXPERIENCED?
 CONSTANTLY (76-100% OF DAY)
 FREQUENTLY (51-75% OF DAY)
 OCCASIONALLY (26-50% OF DAY)
 INTERMITTENTLY (0-25% OF DAY)
- 4 WHAT IS YOUR AVERAGE PAIN INTENSITY?
LAST 24 HOURS/PAST WEEK/LAST 4 WEEKS (CIRCLE ONE)
None Unbearable
0 1 2 3 4 5 6 7 8 9 10
- 5 HOW MUCH HAVE YOUR SYMPTOMS INTERFERED WITH YOUR WORK, HOBBIES OR DAILY ACTIVITIES?
 NOT AT ALL
 A LITTLE BIT
 MODERATELY
 QUITE A BIT
 EXTREMELY
- 6 HOW ARE YOUR SYMPTOMS CHANGING?
 IMPROVING
 NOT CHANGING
 WORSE
- 7 WHO HAVE YOU SEEN FOR YOUR INJURY OR SYMPTOMS?
 NO ONE CHIROPRACTOR MEDICAL DOCTOR PHYSICAL THERAPIST

 OTHER _____
- 8 WHAT TREATMENT DID YOU RECEIVE FOR YOUR INJURY OR SYMPTOMS AND WHEN (APPROXIMATELY)?

- 9 WHAT TESTS HAVE YOU HAD RELATED TO YOUR INJURY OR SYMPTOMS?
 XRAY'S MRI CT SCAN OTHER _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS CORRECT AND ACCURATE

SIGNATURE: _____

DATE: _____



**ORTHOPEDIC ASSOCIATES
THERAPY CENTER**

**CONSENT FOR TREATMENT
HIPAA ACKNOWLEDGEMENT**

CONSENT FOR TREATMENT AND ADMISSION:

I agree to be admitted to ORTHOPEDIC ASSOCIATES THERAPY CENTER as an outpatient, and authorize the therapy staff to evaluate and treat within the scope of physical and occupational therapy practice as ordered by the referring physician.

Initials _____

RELEASE OF INFORMATION:

I hereby authorize ORTHOPEDIC ASSOCIATES THERAPY CENTER to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.

Initials _____

WORKER'S COMPENSATION PATIENTS RELEASE OF INFORMATION:

I authorize ORTHOPEDIC ASSOCIATES THERAPY CENTER to discuss/forward any relevant vocational information, as related to my rehabilitation, with my worker's compensation/group insurance carrier/external case manager.

Initials if applicable _____

ASSIGNMENT OF BENEFITS:

I hereby assign all of my right, title, and interest to ORTHOPEDIC ASSOCIATES THERAPY CENTER of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of ORTHOPEDIC ASSOCIATES THERAPY CENTER customary charges for the services provided. Initials _____

FINANCIAL AGREEMENT:

I assume financial responsibility for the payment of all charges at the time of service unless covered under worker's compensation, Medicare, or a specific insurance carrier. As a courtesy to you, ORTHOPEDIC ASSOCIATES THERAPY CENTER will file your claims to the insurance carrier that you have provided to us. By initialing below you agree for your insurance to be filed. All deductibles, co-insurances, and co-pays including non-covered services are your financial responsibility. Any account not paid will be referred to a third party collection agency to include all reasonable collection fees, not limited to attorney fees, investigative fees, and court costs. Initials _____

CANCELLATION/NO-SHOW POLICY:

As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two(2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of \$15 per incidence.

Initials _____

HIPAA ACKNOWLEDGEMENT:

I have received the Privacy Notice of ORTHOPEDIC ASSOCIATES THERAPY CENTER on today's date. Initials _____

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient and his/her agent to execute the above and accept its terms. If patient's condition prohibits written consent, agent who is present when verbal consent is given should sign patient's name by agent's name. If patient is unable to consent or is a minor, complete the following:

If patient is a minor, how many years of age? _____ If patient is unable to give his/her consent,

why? _____

Patient/Relative/Authorized Agent Signature

Date

Relationship to Patient (if signature is not the patient's)

Witness Signature



**ORTHOPEDIC ASSOCIATES
FLOWER MOUND – DENTON**

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. James Heerwagen, MD; Brady Giesler, MD; Jeffery Cantrell, MD; Kent Dickson, MD; David Evanich, MD; Michael Willenborg, MD; Manuj Singhal, MD; Ian Wilkofsky, MD; Aaron Schrayner, MD; and John McElroy, MD are the owners of Orthopedic Associates Therapy Center.
2. You have the right to choose the provider of your physical therapy services. Therefore, you have the option to use a health care facility other than Orthopedic Associates Therapy Center.
3. You will not be treated differently by your physician if you choose to obtain physical therapy services at a facility other than Orthopedic Associates Therapy Center.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Orthopedic Associates Therapy Center. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Orthopedic Associates Therapy Center.

Signature of Patient

Signature of Parent or Guardian
(If applicable)

Type or Print Name of Patient

Type or Print Name of Parent or Guardian
(If applicable)

Dated: _____