TOWER ORTHOPAEDICS & SPORTS MEDICINE
DEPARTMENT OF PHYSICAL THERAPY

PATIENT INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Sex:(circle) M F

Phone – Home:( )_____-_____ Work:( )_____-_____

Cell : (_____) _____-_____ Email Address:_____

Date of Birth:_____ Referred by:_____

Social Security No.:_____-_____-_____ Marital Status: (circle) S M W D DP

Employer:_____ Occupation:_____

PARENT/GUARDIAN OR SPOUSE

Name:_____ Relationship to Patient:_____

Address:_____

Employer:_____ Business Phone:( )_____-_____

EMERGENCY CONTACT: _____( )_____-_____

INSURANCE INFORMATION – Primary Insurance

Are you a Medicare recipient? ☐ Yes ☐ No (*Please note that we are not a "MediCal" provider.)

Are you receiving or have you received Home Health Care this year through Medicare? ☐ Yes ☐ No

Do you have "MediCal" (Primary or Secondary)? ☐ Yes ☐ No

Signature:_____ Date:_____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow the Tower Orthopedics And Sports Medicine to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physical therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

_____

Signature of Patient

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PATIENT CONSENT & AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care by the Tower Orthopedics And Sports Medicine. I understand that I am under the care and supervision of a licensed physical therapist(s) and it is the responsibility of the staff to carry out the instructions of the physical therapist(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the Tower Orthopedics And Sports Medicine for medical benefits applicable and otherwise payable to me, but not to exceed the physical therapist's regular charges. I specifically direct any second or third party to accept this assignment and pay the physical therapist directly. I understand that I am financially responsible for charges that the insurance carrier declines to pay. In the case that a check is made to the patient or this office and the patient, for services rendered by this office, this document serves as a power of attorney for endorsement on the patient's behalf.

LIEN: In the event that a lien is necessary to protect and ensure payment to the Tower Orthopedics And Sports Medicine, this document serves as notice of lien on any claim I may have and serves as a power of attorney for signature on my behalf on such lien form should or be needed.

RELEASE OF INFORMATION: I authorize the release of information contained in my chart to relevant insurance companies, third parties, attorneys and employers as may be needed to process and manage my case and claims.

REQUEST FOR INFORMATION: I authorize any custodian of records to release medical records and diagnostic studies (including X-Rays) to the Tower Orthopedics And Sports Medicine for the purposes of case management.

HMO DISCLAIMER: I certify that I am not presently enrolled in any health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of my enrollment in an HMO will constitute responsibility for payment of claim on my part.

MINOR'S RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed treatment for the minor.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the therapist prior to the onset of care.

_____ _____

Patient's Name Date

_____ _____

Patient, Patient's Parent/Guardian Signature Acct. #

TOWER ORTHOPAEDICS & SPORTS MEDICINE
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Office Policies

Dear Patient,

Thank you for choosing the Tower Orthopedics And Sports Medicine Department of Physical Therapy for your health care needs. Our office is a state of the art physical therapy clinic offering full service physical therapy services, hand therapy, massage therapy, personal training, sports conditioning programs, evaluation and construction of custom orthotics, as well as, postural and ergonomic education. Our goal in providing physical therapy is to empower the patient with the knowledge and tools for independent self-care.

All patients receive a physical therapy evaluation after which our physical therapist decides on an appropriate course of treatment, if any, that will benefit you. All treatments are provided under the direction and supervision of our highly qualified and stated licensed physical therapists.

Financial Polices

All patients are responsible for their deductibles and co-payments.

Payment Policies

All visits must be **paid in full** at the time of service **unless prior** arrangements have been made and approved by our office manager. The only exceptions to this policy are **1.** ***Medicare*** patients by law have a 24-hour payment period and **2.** Approved ***Workers Compensation*** patients are not required by law to pay for their own treatment, unless it is self-procured.

We gladly accept cash, checks, Visa, MasterCard, and most insurance policies.

Appointment Policies

All visits are on an appointment basis. This means we have specifically reserved a time slot for you. If you need to change or cancel an appointment you must give 24 hours notice or you will be charged a $100 cancellation fee. Monday appointments need to be cancelled on Friday of the week before by 3pm. Appointments following a holiday must be cancelled the business day prior to the holiday. Emergency patients will be seen on first come first served basis or between regularly scheduled patients.

I have read and understand the office policies.

Name _____ Dated _____

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Patient Name: _____ Age: _____ Height: _____ Weight: _____
Family Status: (circle one) S M W D DP with _____ children ages_____
How many are there in your household:_____

PRESENT PROBLEM
When did your symptoms start?_____
Describe your symptoms:_____
Your symptoms increase when:_____
Did your problem require surgery? (if so, please list dates and type of surgery)_____
_____

EMPLOYMENT
(please check one) ___employed ___unemployed ___retired __disability (temporary/permanent)
Present occupation:_____
List current job duties (include posture/stresses):_____
Are you off work due to your current situation? YES or NO If yes, since ___/___/___

GENERAL HEALTH
Describe your general health:_____ Describe your diet:_____
Do you smoke? YES or NO If yes, how much?____ Do you drink? YES or NO how much? ___
Do you take prescribed drugs/vitamins/over the counter medications? (if yes, please list and include how often)_____
_____

MEDICAL HISTORY
List any allergies:_____
Please circle if you have or have had any of the following:

Balance Disorder	High Blood Pressure	Stroke	Skin Disorder
Muscular Disorder	Rheumatic Fever	Tuberculosis	Dizziness
Hearing Disorder	Heart Disorder	Emphysema	Broken Bones
Bladder Disorder	Kidney Disorder	Asthma	Decreased Sensation
Visual Disorder	Excess Bleeding	Arthritis	Osteoporosis
Seizures	Bowel Disorder	Cancer/Tumors	Diabetes
Stomach Disorder	Hepatitis	Pregnant	Pacemaker
Depression/Anxiety	Weight loss/gain	Headaches	Autoimmune Disorder
Anemia	Neurological Disorder	Blood Clot/Cellulitis	Multiple Sclerosis

If you have circled any of the above, please explain:_____
_____
List other conditions for which you received surgery:_____
Have you had X-rays or MRIs? If so, what were the findings? _____
_____

ACTIVITY LEVEL
Describe previous activity level/recreation?_____
Has this changed since this condition?_____

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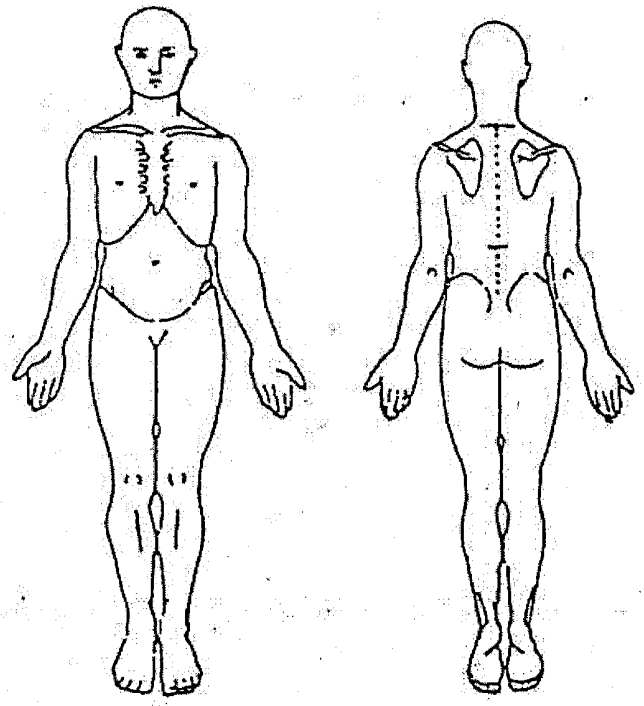
SYMPTOM PATTERNS AND BEHAVIORS

Please indicate on the diagram below where you have symptoms:



Circle any of the activities below that worsen your pain:

Walking	Up Stairs	Down Stairs	Standing	Sitting	Twisting	Bending
Sneezing	Coughing	Stress	Lifting	Lying Down	Carrying	Pulling
Pushing	Chewing	Straining	Swallowing	Talking	Breathing	Reaching Up

What can you do that does NOT cause pain?_____
What can you do to ease your pain?_____
Does your symptoms disturb your sleep? YES or NO. If yes, please explain:_____
How many hours of sleep do you get per day? _____ Is it continuous? YES or NO.
If no, please explain:_____
What position do you sleep in?_____
What bed type do you sleep on? (please circle one) FIRM SOFT SAGGY WATER BED

TREATMENT EXPECTATIONS

What are your goals for treatment?_____
What do you believe will help relieve your pain?_____
What do you believe therapy can do for you?_____

Print Name:_____

Patient Signature:_____ Date: _____