Orthopedic Rehabilitation Specialists

Date_____

Patient Name_____ Date of Birth_____

Address_____ Zipcode_____

Home Phone # _____ Cell Phone #_____ Marital Status_____

S.S.# _____-_____-_____ Driver's License #_____

E-mail Address_____ Referred by: _____

Employer_____ Office Phone#_____

Employer Address_____ Occupation_____

Spouse/Responsible Party_____ Phone #_____

Employer_____ Occupation_____

Primary Insurance_____ ID#_____ Grp#_____

Secondary Insurance_____ ID#_____ Grp#_____

Is this a worker's compensation injury? **YES/ NO** *If yes*, date of injury_____

Employer at time of injury_____ Phone #_____

Worker's comp. Insurance Carrier_____ Claim #_____

Is this an auto accident? **YES/ NO** *If yes*, date of accident_____

Insured's name_____ Policy #_____

Auto Insurance Carrier_____ Phone #_____

Is this a liability or legal case? **YES/ NO** *If yes*, please provide attorney information: _____

Emergency Contact_____ Phone #_____

Relationship_____ Address_____

The following persons are allowed to receive and/or review all my medical records, reports and appointments associated with my treatment. Those who *I authorize* are:

1._____ 2._____ 3._____

I authorize any insurance carrier, employer, hospital or physician to release any information requested with regard to my current physical condition. This authorization shall remain in effect until my course of treatment is completed or it is revoked by me in writing. A photocopy of this is to be considered as valid as the original.

PATIENT SIGNATURE / RESPONSIBLE PARTY

Patient/ Guardian Signature:_____ Relationship to Patient_____

Print Patient Name:_____ Date: _____

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NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: ____/____/____ HEIGHT _____ WEIGHT _____ **L – HANDED – R**

Marital Status: _____ # Children _____ Ages _____ Currently Working Y N

Occupation _____ Referring MD _____

Is your present problem related to: Illness _____ Accident _____ Work-Related _____

Please indicate for which body region(s) are you seeking treatment: (Please Circle)

Neck *Mid Back* *Low Back* *Shoulder* *Elbow* *Hand* *Wrist* *Hip*
Knee *Ankle/foot* *Other*_____

When did your symptoms start? _____

Can you identify a cause for your symptoms? Y N

If yes, specify _____

Have you ever had similar symptoms in the past? Y N
If yes, when? _____

Have you recently had the following tests? (Circle all that apply):

X-Rays *CT Scan* MRI *Bone Scan* Blood Tests *EKG* Echocardiogram

Stress Test *EMG* Pulmonary Function Test *Myelogram*

Pain rating: Indicate your average level of pain by CIRCLING the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain Free **Most Severe**

Have you seen anyone else for this problem? (Circle all that apply)

Physician *Physical Therapist* Chiropractor *Osteopath* Podiatrist

Dentist Psychologist/Psychiatrist *Other*

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NAME: _____

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Describe the character of your **pain**: (Does it feel... sharp, dull, achy, etc.?) _____

Is your pain worse in the **am** _____ **pm** _____?

Is the pain there all the time? **Y** **N**

Do you have numbness, tingling, or weakness? **Y** **N** Location? _____

Have you had any recent changes in your bowel, bladder or sexual function? **Y** **N**

What activities/positions make your pain **worse**? _____

What activities/positions make your pain **better**? _____

HAVE YOU:		IF YES, EXPLAIN:
Experienced any trauma (i.e. motor vehicle accident or fall from a height?	YES NO	_____
Experienced any head trauma / brain injury?	YES NO	_____
Experienced an inability to focus or concentrate recently?	YES NO	_____
Experienced unusual clumsiness or lack of coordination?	YES NO	_____
Had open wounds / redness / cuts / infection recently?	YES NO	_____
Experienced unexplained back or flank pain?	YES NO	_____
Experienced groin/hip/thigh aching or pain that increases with activity?	YES NO	_____
Sustained a blow or trauma to any body part?	YES NO	_____
Recently begun an exercise program or modified an existing program?	YES NO	_____
Taken a long car ride / bus trip /plane ride?	YES NO	_____

PLEASE PROVIDE A LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	Frequency	How Taken (oral, injection, etc.)

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NAME_____

Have you ever suffered from or been told that you have:	YES	NO	Therapist Comments:
High blood pressure			
Thyroid problems			
Diabetes (high blood sugar)			
Osteoporosis			
Circulation or vascular problems			
Seizures / Epilepsy			
Recent / Repeated Infections			
Arthritis / Rheumatoid Arthritis / Gout			
Kidney problems			
Cancer			
Head injury / Headaches			
Heart problems / Pacemaker			
Lung / Respiratory problems / Asthma			
Multiple Sclerosis / Parkinson's Disease			
Stroke / Neurological problems			
Liver Problems / Hepatitis			
Blood disorders / Blood Clots			
Low blood sugar			
Tuberculosis			
Broken bones (fractures)			
Ulcers / stomach problems			
Allergies			
FOR WOMEN ONLY:			
Pelvic inflammatory disease			
Endometriosis			
Any complicated pregnancies or deliveries			
Trouble with your period			
Are you or could you be pregnant?			
FOR MEN ONLY:			
Prostate Disease			
HAVE YOU RECENTLY HAD:			
Unexplained Weight Loss/ Gain			
Fatigue / Tiredness / Malaise			
Diarrhea / Constipation / Incontinence			
Frequent Urination			
Blood in Stool or Urine			
Unexplained fever or chills / sweating			
Shortness of breath / Difficulty Breathing			
Cough / Hoarseness			

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HAVE YOU RECENTLY HAD:	YES	NO	Therapist Comments:
Unexplained fever or chills			
Visual problems / Loss of Vision			
Joint Pain and/or Swelling			
Difficulty Walking			
Nausea / Vomiting			
Numbness or tingling			
Weakness in your arms or legs			
Difficulty swallowing			
Pain at rest			
Pain at night			
New Onset of Headaches			
Hearing Problems			
Loss of appetite			
Chest Pain			
Heart palpitations / Heart Racing			
Dizziness or Loss of Consciousness			
Loss of balance / Any Recent Falls			
Implants / Metal Implants			
Difficulty Sleeping			
DO YOU:			
Smoke?			
If yes, how much? (packs per day)			
Have any significant family history of illness/ disease?			
Have any other medical problems?			

HAVE YOU:			
Had surgery or been hospitalized in the past?	YES	NO	If yes, please explain below
A.	REASON:		DATE:
B.	REASON:		DATE:
C.	REASON:		DATE:
Who is your primary doctor, or the doctor you see most often?			
When was your last general check-up?			DATE:

Please describe your job/social activities and your current ability to perform them:

_____

What do you want to accomplish from your course of Physical Therapy Treatment?

_____

Is there anything else you feel is important to tell me?

_____

Name: _____ **Signature:** _____

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Have you had any type of therapy (OT, PT, Speech or Chiropratic) during 20__ *other than* in our office.

☐ **YES *if so*:**

When_____

Where_____

How Many Visits_____

☐ **NO**

Patient Name:_____

Date:_____

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Hand Crafted Physical Therapy

Patient Name:_____ Date:_____

Are you currently receiving Home Health Care?

YES_____ NO_____

Have you had any type of Home Care Services?

YES_____ NO_____

If yes, provide us with your **Discharge date**:

X_____

8720 NORTH KENDALL DRIVE • SUITE 206 • MIAMI, FLORIDA 33176 • PHONE (305) 595-2425 FAX

Orthopedic Rehabilitation Specialists
HAND-CRAFTED PHYSICAL THERAPY

Patient's History of Current Injury/Illness

Name:_____

	Activity/Function/Skill	Able	Unable	Prior Level of Function (Before Illness/Injury)
1	Rolling over in bed			
2	Getting out of bed			
3	Sitting			
4	Standing			
5	Transfer to/from bath			
6	Getting up from chair			
7	Transfer to/from car			
8	Reaching - level/overhead			
9	Bathing/Showering			
10	Dressing			
11	Grooming			
12	Using Telephone			
13	Walking			
14	Going down stairs			
15	Going up stairs			
16	Stooping/Squatting			
17	Lifting			
18	Carrying			
19	Meal preparation			
20	Driving			
21	Child Care			
22	Household cleaning			
	List Other Activities Affected by Your Symptoms: Sports, Hobbies, Etc.			

Job Description/Social Activities and Ability to Perform Them: _____

_____

_____

What Do You Want to Accompllish from your Course of Physical Therapy Treatment? _____

_____

_____

Patient Signature:_____

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions

Q.1-Q.5 asked of patient; Q.6 answered by Therapist (within the last 12 months)

Patient Name: _____ **Date:** _____

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer

6) **Therapist**: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

Name:_____ Date:_____

PHQ- 9 TEST

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	(*add* Columns) ☐	+ ☐	+ ☐	=

A11 – PHQ9 **TOTAL SCORE**_____

Orthopedic Rehabilitation Specialists

FINANCIAL AGREEMENT

I hereby assign all medical benefits, including major medical benefits, to which I am entitled including Medicare, private insurance and any other health plans or insurance coverage to Orthopedic Rehabilitation Specialists, Inc., including any settlements from lawsuit. Please remember that verification of insurance benefits is not a guarantee of payment. I am responsible for the remaining balance, including deductibles, and non-covered expenses. If for any reason the account is assigned to an attorney for collections and/or lawsuit, Orthopedic Rehabilitation Specialists Inc. will be entitled to reasonable attorney's fees and cost of collections. To the extent necessary to determine liability of our payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical/financial record. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I authorize Orthopedic Rehabilitation Specialists Inc. to release all information necessary to secure payment.

CANCELLATION POLICY

I understand that it is my responsibility to keep scheduled appointments. Failure to cancel with 24 hours notice will result in a $30.00 administration fee. Failure to notify our office may result in a full day visit charge.

CONSENT, USE, DISCLOSURE AND ACKNOWLEDGEMENT OF HEALTHCARE AND PRIVACY PRACTICES

I have had full opportunity to read and consider the contents of the Consent form and the posted Notice of Privacy Practices. Understand that by signing this form I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

INFORMED CONSENT FOR PHYSICAL THERAPY

Physical therapy involves the use of many different types of physical evaluation and treatment. At Orthopedic Rehabilitation Specialists, we use a variety of procedures and modalities to help us to try to improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

The physical responses to a specific treatment can vary widely from person to person. It is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee that our treatment will help the condition for which you are seeking treatment. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis(es), symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risk(s) associated with your exercise(s), your therapist will be glad to answer them.

I acknowledge and understand the statement above. I understand that my treatment program will be explained to me by Orthopedic Rehabilitation Specialists, and that I am able to ask any question or state any concerns. I understand the risks associated with a program of Physical Therapy as outlined to me, and I authorize treatment.

Patient Name (Printed):_____ Date:_____

Patient Signature:_____ Guardian (if under 18)_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/19

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE X

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											
										NPI	
2											
										NPI	
3											
										NPI	
4											
										NPI	
5											
										NPI	
6											
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.