Orland Physical Therapy, Ltd.
Orthopedic & Sports Rehab

Today's Date: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Referred by: ☐ Physician ☐ Insurance Plan ☐ Family/Friend ☐Other

Emergency Information:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Employer Information:

Employer: _____ Occupation _____

Phone #: _____ Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Not Employed

Physician Information:

Referring Doctor: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

Insurance Information:

Insurance Provider: _____ Group/Policy#: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's ID #: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Information (if applicable)**:**

Insurance Provider: _____ Group/Policy#: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's ID #: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Auto or Work Injury Claim (if applicable):

Insurance Provider: _____ ☐Auto ☐ Workers' Comp

Address: _____ City, State: _____ Zip: _____

Adjuster/Claim Manager: _____ Phone #: _____ Claim #: _____

Accident Date: _____ Cause: _____

Attorney Information (if applicable)**:**

Name: _____ Phone #: _____

Address: _____ City, State: _____ Zip: _____

I authorize my insurance benefits to be paid directly to Orland Physical Therapy, Ltd. I understand that I am financially responsible for any balance. I also authorize Orland Physical Therapy, Ltd to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

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Medical History

Patient: _____ Date of Birth: _____

Please check all that apply:

☐ Alzheimer's
☐ Anxiety/Depression
☐ Asthma
☐ Cardiovascular Disease
☐ Current Infection
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Fibromyalgia
☐ Fracture or Suspected Fracture
☐ Headaches/Migraines
☐ Heart Attack Date:
☐ High Blood Pressure
☐ High Cholesterol
☐ History of Cancer (*see below)
☐ Immunosuppression
☐ Lupus
☐ Obesity
☐ Osteoarthritis
☐ Pacemaker
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Stroke
☐ Seizures
☐Thyroid Deficiency
☐ Traumatic Brain Injury

☐ Other:

_____

_____

_____

*If Cancer checked list type, date, and treatment

_____

_____

Exercise
☐ None ☐ 3-4x week
☐ 1-2x week ☐ 5+x week

Work Activity
☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor

Habits
☐ Smoke

List all Medications (Prescription, OTC, and Supplements)

_____

_____

_____

_____

List all Allergies

_____

_____

_____

_____

List all Surgeries and Dates

_____

_____

Have you had any work related injuries? ☐ Yes ☐ No

If yes, list injury and date: _____

Have you had any auto accidents? ☐ Yes ☐ No

If yes, list injury and date: _____

Have you had Physical Therapy before? ☐ Yes ☐ No

If yes, list reason why and date: _____

Are you pregnant: ☐ Yes ☐ No If yes, how many weeks? _____

I authorize that all the above information I provided is current and accurate.

_____ _____

Signature of Patient, Parent, Guardian **Date**

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Pain and Symptom Report

Today's Date: _____

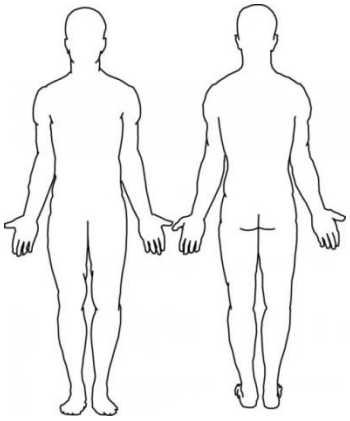
Patient Name: _____ Date of Birth: _____

Using the symbols below, please draw at the locations on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	-- -- --	o o o

Pins & Needles	Stabbing
###	///

Other
xxx



Chief Complaint: _____

Date of First Symptom: _____

2nd Complaint: _____

3rd Complaint: _____

Current Level of Pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Best Level of Pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Worst Level of Pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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CONSENT FOR TREATMENT

I voluntarily consent to receive treatment at ORLAND PHYSICAL THERAPY, LTD. I permit its employees and all other persons caring for me to treat me in ways they judge are necessary and proper in diagnosing and treating my physical condition. No guarantees have been made to me about the outcome of this care.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled to ORLAND PHYSICAL THERAPY, LTD in the event they file on my behalf. I hereby authorize said assignee to release all information, verbal and written, contained in my medical records, to secure payment. I understand that I am financially responsible for all charged whether or not paid by said insurance. Verification of benefits is not a guarantee of payment according to actual benefits quoted. In the event that my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount as well as all reasonable costs associated with the collection of this debt, including but not limited to collection of service fees, attorney's fees, and all court costs and additional legal fees.

NO SHOW / CANCELLATION POLICY

We at ORLAND PHYSICAL THERAPY, LTD are dedicated to assisting you meet your therapy goals. In order to do this, it is important that you attend all your scheduled appointments. We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another patient. You can call us at 708.403.5199. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to enforce this policy, you will be charged $25.00 if you cancel an appointment less than 24 hours before your scheduled appointment and $50.00 if you do not show for your appointment. If you are a worker's compensation patient, please be advised that your employer, physician, and case manager will be notified of each missed appointment.

MEDICARE ASSIGNMENT (if applicable)

I certify that the information I gave in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable to ORLAND PHYSICAL THERAPY, LTD and I understand that I am responsible for any health deductibles and co-insurance amounts not covered by Medicare and/or my secondary insurance.

FINANCIAL RESPONSIBILTY

I understand that insurance coverage is not guaranteed of payment, and that I am ultimately responsible for services rendered at ORLAND PHYSICAL THERAPY, LTD. I will honor ORLAND PHYSICAL THERAPY, LTD's payment policy as stated below: • All co-payments and cash payment are due in full at the time of service • Co-insurance and deductibles are the patient's responsibility and will be invoiced once the patient's insurance provider provides the Explanation of Benefits (EOB). Invoices will be due 30 days after receipt. • I authorize payment of benefits directly to ORLAND PHYSICAL THERAPY, LTD for services provided. • ORLAND PHYSICAL THERAPY, LTD has the right to consult a collection agency if payment is past due 90 days. If any portion of the account balance exceeds 90 days the patient will be responsible for this amount plus interest at 1.5% per month. • I understand that I am financially responsible for payment of all services that are not paid by my insurance provider. Should my account be referred to collection, I will be responsible to pay costs of collections, including legal fees. • I understand fee of $35.00 will be assessed for any check returned unpaid.

HIPPA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read the Notice of Privacy Practices for ORLAND PHYSICAL THERAPY, LTD. The therapist is required by applicable federal and state law to maintain the privacy of your protected health information. We are required to give you a notice about our policy practices and your rights concerning protected health information. We reserve the right to change our policy privacy practices. A copy of our Notice of Privacy Practices is available to you upon your request.

☐ I do not give permission to Orland Physical Therapy, Ltd to speak to any other person regarding my treatment
☐ I do give permission to Orland Physical Therapy, Ltd to speak to another person regarding my treatment (list name(s) below)

I have read and agree to the terms and policies listed above.

Patient/Guardian Signature _____ Date _____

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Medicare Policy
Assignment of Benefits

Medicare will pay 80% of allowed charges after Part B deductible. Medicare no longer limits physical therapy, however once a patient has reached $3,000 of allowed charges, Medicare can review claims for payment. Medicare does not cover any supplies or braces. I understand that I am financially responsible for any charges or supplies that are not covered by Medicare or my secondary insurance plan.

I give permission to Orland Physical Therapy, Ltd. to release any records related to my treatment to my insurance company, physicians, assignees and/or beneficiaries.

_____ _____
Signature of Patient Date

Patient Information:

Name:_____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Social Security #: _____ Home Phone: _____

Cell Phone: _____ Patient Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referring Physician: _____ Primary Care Physician: _____

Employer: _____ Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Is this injury the result of an accident? ☐ YES ☐ NO Date of Injury:_____

Is a lawsuit pending regarding this accident? ☐ YES ☐ NO

Did you receive any Home Healthcare Services? ☐ YES ☐ NO Date of Discharge: _____

Have you had physical therapy this year? ☐ YES ☐ NO

Emergency Contact: _____ Relationship to Patient: _____

Home Phone #:_____ Cell Phone #: _____

Secondary Insurance Information:

Name of Insurance Provider: _____

Group #: _____ Phone #: _____