## Patient Registration

Insurance Policy Id#: Date of Birth:

Last Name: Suffix: First Name: MI:

Address:

City: State: Zip:

Phone #'s Home: Cell: Work:

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other ☐

SS# - - Email:

Referring Doctor: Referral Phone:

Primary Care Physician: Primary Physician Phone:

## Insured Party/Responsible Party

Same as patient ☐ yes ☐ no (If yes leave this section blank)

Relationship to patient: Insurance Policy Id#:

Last Name: Suffix: First Name: MI:

Address:

City: State: Zip:

Phone #'s Home: Cell: Work:

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐ Other Email

## Patient's Employer Information

Employer Name:

Job Title:

Employer Address:

City: State: Zip:

## Insured/Responsible Party's Employer Information

Employer Name:

Job Title:

Employer Address:

City: State: Zip:

## Emergency Contact Information

Last Name: First: MI:

Relationship to patient: Spouse ☐ Parent ☐ Friend ☐ Other ☐ Specify:

Phone #'s Home: Cell: Work:

## Patient Certification and Signature

**I certify that all of the information provided herein is true and correct**

Patient/Guardian Signature Date

## Medical History

Reason for therapy:

Date of injury or onset:

Is the reason for treament accident related? **Yes** ☐ **No** ☐

If yes please check one: Auto ☐ Work ☐ Other ☐

If auto accident list state where accident occurred:

If other please explain:

Are you receiving any other care for the condition mentioned above? **Yes** ☐ **No** ☐ If yes please list:

Have you received treatment in the past for the condition mentioned above? **Yes** ☐ **No** ☐ If yes please list:

Was the treatment successful? **Yes** ☐ **No** ☐ Handed **R** ☐ **L** ☐

Have you received therapy services for other problems/conditions during the past 12 months? **Yes** ☐ **No** ☐ If yes please list:

Could you be or are you pregnant? **Yes** ☐ **No** ☐ #of Pregnancies #of Births Vaginal C-Section

## Do you now have or have you ever had any of the following conditions?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Arthritis | **Yes** ☐ **No** ☐ | Diabetes | **Yes** ☐ **No** ☐ | Numbness / Tingling | **Yes** ☐ **No** ☐ |
| Osteoporosis | **Yes** ☐ **No** ☐ | Anemia | **Yes** ☐ **No** ☐ | Thyroid problems | **Yes** ☐ **No** ☐ |
| High Blood Pressure | **Yes** ☐ **No** ☐ | Swelling in Ankles | **Yes** ☐ **No** ☐ | Headaches | **Yes** ☐ **No** ☐ |
| Heart Disease / Heart Attack | **Yes** ☐ **No** ☐ | Deep Vein Thrombosis (DVT) | **Yes** ☐ **No** ☐ | Head injury / Concussion | **Yes** ☐ **No** ☐ |
| Pacemaker | **Yes** ☐ **No** ☐ | Seizures/Epilepsy | **Yes** ☐ **No** ☐ | Hernia | **Yes** ☐ **No** ☐ |
| Stroke | **Yes** ☐ **No** ☐ | Fatigue / Weakness | **Yes** ☐ **No** ☐ | Kidney / Bladder problems | **Yes** ☐ **No** ☐ |
| Vascular Disease | **Yes** ☐ **No** ☐ | Cancer / Tumor | **Yes** ☐ **No** ☐ | Previous fractures | **Yes** ☐ **No** ☐ |
| Hypersensitivity to Heat/Cold | **Yes** ☐ **No** ☐ | Recent weight loss or gain | **Yes** ☐ **No** ☐ | Previous surgeries | **Yes** ☐ **No** ☐ |
| Asthma | **Yes** ☐ **No** ☐ | HIV / AIDS | **Yes** ☐ **No** ☐ | Metal in body or surgical implants | **Yes** ☐ **No** ☐ |
| Shortness of Breath | **Yes** ☐ **No** ☐ | Hepatitis | **Yes** ☐ **No** ☐ | Depression | **Yes** ☐ **No** ☐ |
| Chronic Cough | **Yes** ☐ **No** ☐ | Tuberculosis | **Yes** ☐ **No** ☐ | Anxiety | **Yes** ☐ **No** ☐ |
| Dizziness / Lightheadedness / Fainting Spells | **Yes** ☐ **No** ☐ | Recurrent infection (s) in the past 3 months | **Yes** ☐ **No** ☐ | Smoking | **Yes** ☐ **No** ☐ |
| Nausea/Vomiting | **Yes** ☐ **No** ☐ | Fever / Chills | **Yes** ☐ **No** ☐ | Other (please describe below) | **Yes** ☐ **No** ☐ |

If you answered yes on any of the above conditions or have ny condition that isn't listed above please explain and give approvimate dates:

Do you have any allergies: Yes ☐ No ☐ If yes please list:

Are you presently taking any medications? Yes ☐ No ☐ If yes please list:

Do you take any over the counter vitamins, supplements, minerals etc.?

At the present time would you say your health is: Excellent ☐ Very Good ☐ Fair ☐ Poor ☐

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature Date

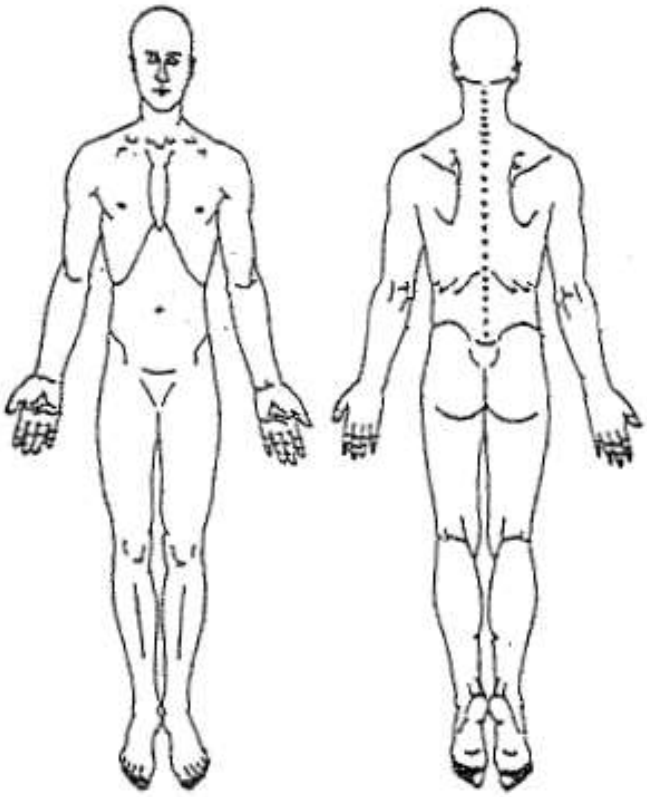
# Pain Diagram and Pain Rating

**Name:** _____ **Date:** _____

**INSTRUCTIONS:** Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

| | | | | | |
|---|---|---|---|---|---|
| **Pins and Needles** | **= / / / / / /** | **Stabbing** | **= SSSSSS** | **Other** | **=OOOOOO** |
| **Burning** | **= XXXXXX** | **Deep Ache** | **= ZZZZZZ** | | |



Please rate your current level of pain on the following scale (check one):

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
(no pain) (worst imaginable pain)

# OSS Physical Therapy

**Orthopedic & Sports Specialists**
1309 W Guadalupe Rd, Suite 1
Mesa, AZ 85202

## AUTHORIZATION FOR TREATMENT

Physical/Occupational Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, national origin or disability, five days a week.

The purpose of Physical/Occupational Therapy is:

- To treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, exercise, and physical agents including but not limited to mechanical devices, heat, cold, air, light, water, electricity and sound in the aid of diagnosis or treatment.
- To obtain, for the physician, information needed in diagnosis and evaluation of patients.
- To prevent or minimize residual physical and mental disability.
- To aid the patient in achieving maximum potential within his/her capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before they are performed. There are certain inherent risks with PT/OT treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but the risk is small. You will be able to control any procedure by stopping if you feel and increase in pain or discomfort. The Physical/Occupational Therapist and or assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform. Based on this information, I agree to cooperate fully and to participate in all Physical/Occupational Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS FOR PERSONAL SAFETY: DO NOT USE ANY EQUIPMENT WITHOUT A STAFF MEMBER PRESENT.

| | |
|---|---|
| _____ | _____ |
| **Patient Name (printed)** | **Legal Guardian Name (printed)** |
| _____ | _____ |
| **Patient/Guardian Signature** | **Date** |
| _____ | _____ |
| **Witness Signature** | **Date** |

# Patient Information Consent Form

I have read and fully understand OSS Physical Therapy's Notice of Information Practices. I understand that OSS Physical Therapy may utilize or disclose my personal health information in order to carry out treatment, to obtain payment, to evaluate the quality of care provided, and any administrative operations related to treatment or payment. I understand that I may request a restriction of the dissemination of my health information in the above cases, but OSS Physical Therapy does not have to honor these requests legally.

I hearby consent to the use and disclosure of my health information for purposes as noted in the OSS Physical Therapy Notice of Information Practices. I understand that I have the right to revoke this consent in writing at any time.

| | |
|---|---|
| _____ | _____ |
| **Patient Name (printed)** | **Legal Guardian Name (printed)** |
| _____ | _____ |
| **Patient/Guardian Signature** | **Date** |
| _____ | _____ |
| **Witness Signature** | **Date** |

# Designated Individuals Authorization

I hereby authorize one or all of the below listed designated parties to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand the identity of designated parties must be verified before release of any information.

Authorized Designees:

Spouse: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

| | |
|---|---|
| _____ | _____ |
| **Patient/Guardian Signature** | **Date** |

# MEDICAL ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

OSS Physical Therapy is pleased to be a part of your rehabilitation experience. We believe that communication with our patients regarding our financial policy assists in providing the best service to you.

**INSURANCE BILLING: We will gladly call your insurance company to identify your coverage for your physical therapy services however, please understand that insurance companies will not guarantee this coverage. We can only use this information as a guideline. We strongly encourage you to contact your insurance company directly in order to understand your plans coverage and limitations.** Please note that we will only bill your primary insurance carrier except for Medicare patients, when we will a secondary carrier. Your insurance company may also require a current therapy prescription written by a physician, a letter of medical necessity and/or pre-authorization obtained by your doctor's office before physical therapy services can be provided. Non-compliance with any of these may result in services not reimbursed by your insurance company.

**PAYMENTS: All deductibles, co-pays, co-insurance and full cash payments are due at the time of services unless a written agreement has been made between the responsible party and OSS Physical Therapy**. Any insurance payments sent directly to the patient must be remitted to OSS within 5(five) days of receipt. If a balance remains after all the payments have been processed, a final statement will be sent to you. Payment will be due, in full no later than 30(thirty) days from the date of the final statement. There will be a $35.00 returned check fee and subsequent payments must be made in cash or credit card only. If you have any questions regarding the above information, please contact a OSS Physical Therapy staff member.

I, the patient (or legal guardian/responsible party for the patient), understand and agree that I am 100% responsible for all fees incurred at OSS Physical Therapy. I agree to authorize OSS Physical Therapy to release any medical information to insurance company, physicians, attorneys, and to all pertinent parties that may be involved in my claim or care. I also agree to assign all payments of benefits to OSS Physical Therapy.

## Cancellation/Rescheduling Policy

Dear Physical Therapy Patients,

OSS Physical Therapy seeks to provide the best patient experience available to all of our patients. We have an outstanding group of physical therapists who want your outcome to be the best possible. A positive outcome involves following your physicians and physical therapists plan of care.

Our physical therapists are also very accommodating of our patients scheduling needs. However, in an effort to most effectively schedule patients during the days and times of the day, we need your help. We request that you notify us 24 hours prior to canceling an appointment. We also realize that a change in your schedule may occur in less than 24 hours. If that does occur, please call us and reschedule that days appointment within two (2) business days. If we do not receive a call 24 hours prior to an appointment or your appointment is not rescheduled within two (2) business days, we reserve the right to bill your account **$25.00**. This charge will not be covered by insurance. If you cancel or no-show for three (3) consecutive appointments, you may be discharged from therapy and your physician will be notified.

If you are an Industrial or Work Injury Patient, your claims manager will be notified about the missed visits.

We ask that you please be on time for your appointment; if you are more than 15 minutes late, it will be up to your therapist's discretion whether or not you will be seen. This is a courtesy to the other patients that are scheduled at their time. We reserve the right to cancel or reschedule any appointment if you are more than 15 minutes late. Our desire is to maintain a level of care that has made OSS Physical Therapy in demand from our community and the medical providers which refer us patients.

**We thank you for your support and understanding**.

**Sincerely,**

**The OSS Physical Therapy Team**

| | |
|---|---|
| _____ | _____ |
| **Patient Name (printed)** | **Legal Guardian Name (printed)** |
| _____ | _____ |
| **Patient/Guardian Signature** | **Date** |
| _____ | _____ |
| **Witness Signature** | **Date** |

# DRY NEEDLING CONSENT & INFORMATION FORM

**What is Dry Needling?**
Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments, or near nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling is not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy *("Qjll)* along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis, or low-back pain.

**Is Dry Needling safe?**
Drowsiness, tiredness or dizziness occurs after treatment in a small number of patients (1-3%) and if affected, you are advised not to drive. Minor: bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during dry needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment (less than 3% of patients); however, this is not necessarily a "bad" sign. Fainting can occur in certain patients (0.3%), particularly at the first treatment session when needling the head or neck regions. Dry needling is very safe; however, serious side effects can occur in less than 1 per 10,000 (less than 0.01%) treatments. The most common serious side effect from dry needling is pneumothorax (lung collapse due to air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, a dry cough, bluish discoloration of the skin, or excessive sweating. If such signs and/or symptoms occur, you should immediately contact your physical therapist or physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness or tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000).

**Is there anything your practitioner needs to know?**
1. Have you ever fainted or experienced a seizure? YES ☐ NO ☐
2. Do you have a pacemaker or any other electrical implant? YES ☐ NO ☐
3. Are you currently taking anticoagulants (blood-thinners e.g. Aspirin, Warfarin, Coumadin)? YES ☐ NO ☐
4. Are you currently taking antibiotics for an infection? YES ☐ NO ☐
5. Do you have a damaged heart valve, metal prosthesis or other risk of infection? YES ☐ NO ☐
6. Are you pregnant or actively trying for a pregnancy? YES ☐ NO ☐
7. Do you suffer from metal allergies? YES ☐ NO ☐
8. Are you a diabetic or do you suffer from impaired wound healing? YES ☐ NO ☐
9. Do you have hepatitis B, hepatitis C, HIV, or any other infectious disease? YES ☐ NO ☐
10. Have you eaten in the last two hours? YES ☐ NO ☐

**Single-use, disposable needles are used in this clinic.**

**STATEMENT OF CONSENT**
I confirm that I have read and understand the above information, and I consent to having dry needling treatments. I understand that I can refuse treatment at any time.

| | |
|---|---|
| **Patient Name (printed)** | **Legal Guardian Name (printed)** |
| **Patient/Guardian Signature** | **Date** |

## How Did You Hear About Us?