Orthopaedic Motion & Sport
Physical Therapy

Ft. Myers, FL Louisville, KY Nashville, TN

Thank you for choosing us and our facility to serve you!
Please print and fill out forms completely. If you have any questions or need assistance, please ask.
We will be happy to assist you.

I. PATIENT INFORMATION

Name:_____ **Date**: _____/_____/_____
(First) (Middle) (Last)

Address:_____ ☐ Male ☐ Female
(Street Address) (City, State) (Zip)

Date of Birth (DOB): _____/_____/_____ **Social Sec. #**: _____-_____-_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email: _____ **Home Phone #**: (_____)_____-_____ **Cell Phone #**: (_____)_____-_____

☐ **Retired** ☐ **Unemployed** **Employer**: _____ **Occupation** *(Present or Previous)*:_____

Employer Phone #: (_____)_____-_____ **Employer Address**: _____
(City, State) (Zip)

Emergency Contact: **(Not living in your home)** _____ **Phone #**: (_____)_____-_____

Relationship to Patient: ☐ Parent/Guardian ☐ Child ☐ Friend ☐ Other: _____

Primary Care Doctor: _____ **Referring Doctor**: _____

Return appt. with Referring Doctor: _____/_____/_____

How did you hear about us and what influenced you to choose this clinic? **_____Previous Patient** **_____Friend/Family Member**

_____Social Media/Internet **_____Brochure/Advertisement** **_____Physician Referral**

AUTHORIZATION & RELEASE

I authorize, give consent to treat and hereby assign/transfer, to OMSPT my rights, title, and interest to my medical reimbursement benefits under my insurance policy for the services rendered by Orthopaedic Motion & Sport Physical Therapy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by giving written notice. I understand that I am financially responsible for all charges covered or non-covered by insurance policy provided.

I understand that I am financially responsible for all charges covered or non-covered by insurance policy. I give my permission to use my picture, and likeness on marketing material, and to receive marketing material in the future from Tri-State Rehab Services.

Patient's Signature:_____ Date:_____/_____/_____
(Must be signed by responsible party or the parent/legal guardian of minor children)

For Medicare Patients:

I certify the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize OMSPT to release information concerning treatment to the Health Care Financing Administration or its intermediaries/carriers which may be required for processing my Medicare claims. I authorize OMSPT to submit claims and receive payment for authorized services to Medicare intermediaries/carriers on my behalf.

Patient's Signature:_____ Date:_____/_____/_____
(Must be signed by responsible party)

RESPONSIBLE PARTY INFORMATION IF PATIENT IS UNDER THE AGE OF 18

Responsible Party's Name:_____ DOB: _____/_____/_____

Relationship to Patient:_____ Social Security #:_____-_____-_____ Phone #: (_____)_____-_____

E-mail of Responsible Party: _____ Employer: _____

Address of Responsible Party:_____
(City) (ST) (Zip Code)

INSURANCE INFORMATION: (This portion must be filled out for us to legally bill your insurance company)

Primary Insurance/Policy Holder's Name: _____ Policy #:_____

Policy Holder's Employer: _____ Soc. Sec. # of insured:_____-_____-_____ DOB:_____/_____/_____

Other Insurance/Policy Holder's Name: _____ Policy #: _____

Policy Holder's Employer: _____ Soc. Sec. # of insured: _____-_____-_____ DOB:_____/_____/_____

Is this a Worker's Comp claim? ☐ Yes ☐ No **(*We bill Worker's Comp for you but should the claims be denied we will request your health insurance.).***

II. MEDICAL HISTORY

Patient Name:

PRESENT OR PAST CONDITIONS / DIAGNOSES ☐ None, I have not been previously diagnosed with any conditions.

Allergies ☐ Yes ☐ No	Diabetes *Type: 1 2* ☐ Yes ☐ No	Metal Implants ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Dizzy Spells ☐ Yes ☐ No	MRSA ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No	Emphysema/Bronchitis (COPD) ☐ Yes ☐ No	Multiple Sclerosis (MS) ☐ Yes ☐ No
Arthritis/Osteoarthritis (OA) ☐ Yes ☐ No	Fibromyalgia ☐ Yes ☐ No	**Muscular Disease** ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	**Fractures** ☐ Yes ☐ No	**Osteoporosis/Osteopenia** ☐ Yes ☐ No
Autoimmune Disorder ☐ Yes ☐ No	Gallbladder Problems ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Headaches/Migraines ☐ Yes ☐ No	Rheumatoid Arthritis (RA) ☐ Yes ☐ No
Cardiac Conditions ☐ Yes ☐ No	Hearing Impairment ☐ Yes ☐ No	Seizures/Epilepsy ☐ Yes ☐ No
Cardiac Pacemaker ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Smoking **MIPS** ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Speech Problems ☐ Yes ☐ No
Circulation Problems ☐ Yes ☐ No	High/Low Blood Pressure ☐ Yes ☐ No	Stroke(s) ☐ Yes ☐ No
Covid-19 ☐ Yes ☐ No	HIV/AIDS ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Currently Pregnant ☐ Yes ☐ No	Incontinence ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Depression ☐ Yes ☐ No	**Kidney Problems** ☐ Yes ☐ No	Vision Problems ☐ Yes ☐ No

If you answered yes to any of the conditions above in **bold text**, please use the back of this page to specify and provide additional details.

Over the last 2 weeks, how often have you been bothered by 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**

Have you been physically or emotionally threatened, hurt, made to feel afraid by your partner or someone close to you? ☐ Yes ☐ No

Please answer the following questions as thoroughly and accurately as you can in order to allow your therapist to best serve your needs.

Height: _____ feet _____ inches **How would you rate your overall health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Weight: _____ pounds **Are you allergic to Latex or Adhesives?** ☐ Yes ☐ No

SURGICAL HISTORY

Surgery or Procedure	Body Region	Date (month/year)

MEDICATIONS **Please list current medication(s) below or provide an attached list**

☐ **OR: I am not currently taking medications**

Medication	Condition/Reason Taking	Dose	Frequency

FALL HISTORY Injury is result of a fall in the past year? ☐ Yes ☐ No Two or more falls in the last year? ☐ Yes ☐ No
Patient is at risk for falls? ☐ Yes ☐ No

HOME SAFETY Do you have to climb stairs? ☐ Yes, how many? _____ ☐ No Do you live alone? ☐ Yes ☐ No
Do you have to step into a bathtub? ☐ Yes ☐ No Do you have a walk-in shower? ☐ Yes ☐ No

What date was your surgery or injury, or approximately how long ago did your condition begin? _____

For your present condition, please indicate the following medical tests and/or treatments you have received: ☐ None

☐ MRI ☐ CT scan ☐ Radiograph (X-ray) ☐ Injections ☐ Chiropractor ☐ Physical/Occupational therapy

☐ OTC medications (Tylenol/Advil/Ibuprofen) ☐ Prescription medication(s) ☐ Other(s): _____

On a scale of 1-10, with 10 being the worst, rate your pain at rest.

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, with 10 being the worst, rate your pain with activity.

1 2 3 4 5 6 7 8 9 10

What is your pain frequency?

☐ 10% of the time ☐ 11% to 25% of the time

☐ 26% to 75% of the time ☐ Greater than 75% of the time

How often is your sleep affected by the pain?

☐ Never ☐ Less than 10% of the time

☐ 11% to 25% of the time ☐ 26% to 75% of the time ☐ Greater than 75% of the time

What activities, positions or movements… INCREASE your pain? _____

DECREASE your pain? _____

What are your goals and expectations for physical therapy?

☐ Decrease pain ☐ Less difficulty with daily and/or work activities ☐ Sleep better and longer

☐ Improve strength and mobility ☐ Return to recreational activities, hobbies, sports, work ☐ Other(s):

_____

Have you been seen by a Physical Therapist, Chiropractor, Occupational Therapist in the past 12 months? Yes _____ No _____

If yes, where you were seen and how many visits? _____

If you are a Medicare patient, do you currently receive home health services? Yes _____ No _____

(i.e. physical therapy, speech therapy, occupational therapy, respiratory therapy, nurse's aide)

If yes, name of home health agency? _____

Have you recently experienced *UNEXPLAINED*:

Weight loss or gain ☐ Yes ☐ No

Nausea or vomiting ☐ Yes ☐ No

Dizziness, vertigo, or lightheadedness ☐ Yes ☐ No

Fatigue or weakness ☐ Yes ☐ No

Changes or difficulty with bladder function? ☐ Yes ☐ No

Night pain or night sweats? ☐ Yes ☐ No

Fever or chills? ☐ Yes ☐ No

Numbness or tingling ☐ Yes ☐ No

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Consent for use and disclosure of protected health information (HIPAA)

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personal identifiable health information about me by OMSPT (the "practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.
2. I am aware that the practice maintains a privacy notice which sets forth the types of uses and disclosures that the practice is permitted to make under the privacy regulations and sets forth in detail the way in which the practice will make such use or disclosure. By signing this consent, I understand and acknowledge that I have the right to review the privacy notice prior to signing this consent.
3. I understand and acknowledge that in its privacy notice, the practice has reserved the right to change its privacy notice as it sees fit from time to time. If I wish to obtain a revised privacy notice, I need to send a written request for a revised privacy notice to the office of the practice at the following address: 2700 Greenup Ave, Ashland, KY 41101 Attention: Practice Compliance Director
4. I understand and acknowledge that I have the right to request that the practice restrict how my information is used or disclosed to carry out treatment payment or healthcare operations. I understand and acknowledge that the practice is not required to agree to restrictions requested by me, but if the practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the practice's use and/or of my health information **(leave blank if no restrictions)**: _____
5. I understand and acknowledge that I may revoke this consent at any time by sending a written revocation to the practice at the address set forth in (3) above. However, I also understand and acknowledge that if I revoke this consent, my revocation will not be effective to that extent that the practice has already acted in reliance on this consent.
6. I understand the foregoing provisions, and I wish to sign this consent authorizing the use of my personal, identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed this consent and agree to the practice's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE **DATE**

_____ _____
PATIENT'S NAME **DATE OF BIRTH**

_____ _____
NAME OF PERSONAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

TO BE COMPLETED BY OMSPT REPRESENTATIVE

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____Accepted _____Denied _____Not Applicable _____Other (explain)

_____ _____
SIGNATURE OF AUTHORIZED CLINIC REPRESENTATIVE **Date**

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NEW PATIENT ORIENTATION SHEET

PHYSICIAN APPOINTMENTS
Each time you return to your referring physician, please notify our office at least 48 hours in advance, so we can prepare a progress note regarding your physical therapy treatment.

MEDICARE PATIENTS
Your referring physician must sign a plan of care/treatment which will be set by the evaluating physical therapist to assist in achieving your functional goals. This plan of care/treatment can be for a period of up to 90 days in accordance with government mandates. This plan of care will be sent to your referring physician with the initial evaluation letter.

KEEPING APPOINTMENTS
We ask that you arrive on time and keep all scheduled appointments unless a true emergency arises. Missed appointments have resulted in our patients being denied further worker's compensation benefits. We reserve the right to bill you $50.00 for missed appointments without a 24-hour notice of any appointment change or reschedule.

YOUR FINANCIAL RESPONSIBILITIES
Your insurance company requires that you present your insurance card. We will call your insurance company to verify what your financial responsibilities will be for your physical therapy services. If your insurance policy does not pay 100% of your physical therapy treatments, any co-payments, co-insurance, and/or deductible amounts are due at the time of service. **If your insurance coverage changes during treatment, please let us know**, so that we may re-verify your insurance and make you aware of any changes to your physical therapy benefits. We cannot guarantee the benefits quoted by your insurance company. Insurance verifications are not a guarantee of payment by your insurance carrier.

You are responsible for any charges that your insurance deems your responsibility. It is your responsibility to know your insurance benefits. If they determine your coverage to be different at the time of claims processing, you will be billed any balance due that is deemed your responsibility. We accept cash, checks and most major credit cards. A 1.5% monthly finance charge (18% APR) **may be applied** to accounts with any remaining patient balances over 30 days from the time the last insurance payment is received.

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time you provide a wireless telephone number you consent to receiving calls or text messages which include but are not restricted to communications regarding billing and payment for items and services. You must notify OMSPT to the contrary in writing to opt out. Calls/text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, electronic mail, text messaging or any other form of electronic communication from OMSPT, its affiliates, contractors, servicers, attorneys or its agents including collection agencies.

CONSENT TO E-MAIL USAGE: If at any time you provide an email address at which you may be contacted, unless you notify OMSPT to the contrary in writing, you consent to receiving statements, bill and marketing material for services and payment receipts at that email address from OMSPT.

I give my permission to use my picture, and likeness on marketing material, and to receive marketing material in the future from OMSPT. Yes _____ No _____

Patient's Signature_____ **Date:**_____

Witness Signature_____ **Date:**_____

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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 is 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 ("Qi") 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 shunt, pacemaker, or any electrical implants? 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 to get pregnant? 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.

☐ **OR: I choose not to receive Dry Needling treatment. (please check box for this option)**

Patient's Signature: _____ DATE: _____

Witness Signature: _____ DATE: _____