PATIENT MISSED APPOINTMENT/TARDY POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you, we think it would be a disservice if we did not emphasize the importance of **your own commitment** to the care you need to receive and to the action we ask you to do.

First, **please arrive on time for your appointment**. If you arrive more than 15 minutes late for your appointment, you may be asked to wait until your therapist is available or more likely, to reschedule your appointment and have a cancellation recorded for that day.

Next your **adherence to the recommended number of treatments is a vital** component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. We will write down the time and date of your visits you can keep as a reminder. **Do Not Forget!**

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, **we reserve the right** to charge you a **$20.00 fee**.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this Policy:_____ date:_____

Orthopedic Physical Therapy Specialists, LLC
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Registration Form (Please Print)

PATIENT INFORMATION					**Date:**
How would you like to be addressed?					
Social Security Number	Last Name	First Name	MI	e-mail address	
Address		Zip Code	City	State	Telephone Number
Date of Birth	Sex (Circle one) Male or Female	If minor name of parent or guardian			
Martial Status (Circle One) Married Divorced Single Widowed Separated	Employment Status (Circle One) Retired Full Part None		Student (Circle One) Full Part None		Relationship to Insured (Circle One) Child Self Spouse Other
Employer		Position			
Address		Zip Code	City	State	Employer's Phone Number

RESPONSIBLE PARTY (If Patient is responsible party, skip this section)			
Employed (Circle) Yes No	Last Name	First Name	MI
Address	Zip Code	City	State
Relationship to Insured (Circle One) Child Self Spouse Other	Social Security Number		Date of Birth
Employer	Position		Business Phone Number/CellPhone #

INSURANCE INFORMATION			
Primary Insurance Company	Policy # :	Name of Insured	
	Group #:	Social Security #:	
Address:	ID #	Date of Birth:	
Secondary Insurance Company	Policy #:	Name of Insured	
	Group #:	Social Security #:	
Address:	ID # :	Date of Birth:	
Employer:		Relationship to Insured (Circle One) Child Self Spouse Other	
If work comp, please provide claim number:			
Name of Rehab nurse:	Contact #:		

EMERGENCY INFORMATION			
Person to contact in case of Emergency	Relationship	Phone Number to Contact	
Address	City	State	Zip

02957 73rd Street South Haven, MI 49090 Phone: 269-637-9099 Fax: 269-637-9224 web: opts-southhaven.com

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MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name::_____Date:____/____/____ Birth date: ____/____/____ Age:_____

Referring Physician:_____ Phone #: _____

Family Physician (if different):_____ Phone #:_____

Diagnosis: _____

Medical History: (Check all conditions that apply to you)

Heart/Circulation	Check	Pain	Check	Medical Conditions	Check
Heart Disease		No Pain Anywhere		HIV/AIDS	
Stroke		Feet		Fainting Spells	
Pacemaker		Knees		Shortness of Breath	
Heart Surgery		Ankles		Dizziness	
Discomfort in Chest		Hips		Kidney Disease	
Angina		Shoulders		Thyroid Problems	
High cholesterol		Abdomen		Difficulty Breathing	
High triglycerides		Low Back		Labored Breathing	
Ankle Swelling		Mid Back		Lung Problems	
High Blood Pressure		Neck		Cancer	
		Head		Depression	
Family History				Anxiety	
Heart Attack				Visual Impairment	
Heart Disease				Hearing Impairment	
High Blood Pressure		**Surgical History**		Cigarette Smoker	
Diabetes		Low Back		Former Smoker	
Other:		Mid Back		Seizures	
		Neck		Diabetes	
		Shoulder		Tuberculosis	
Bones and Joints		Abdomen		Hepatitis	
Fracture		Hip		Latex Allergy	
Osteoporosis		Knee		Other Allergies	
Osteoarthritis		Ankle		Pregnant	
Scoliosis		Foot		Kidney Problems	
Fibromyalgia		Other:		Epilepsy	
Rheumatoid Arthritis				Fibromyalgia	
Dropped Arches/Feet				Headaches	
Hip Replacement					
Knee Replacement					
Shoulder Replacement					
Deg. Joint Disease					

Have you had surgery for your condition? Y N If yes, please give approximate date:_____

Have you had any injections for your condition? Y N If yes, please give approximate date:_____

Please list any diagnostic tests you have had for this condition: _____

Please list any **medications** that you are taking: _____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset:_____ **Best** pain since onset:_____ **Today's** pain:_____

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CONSENT FOR TREATMENT, ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILITY.

1. **MEDICAL CONSENT:** The undersigned hereby authorize provider to render to Patient physical therapy, occupational therapy or other related services (collectively referred to as "Services") that Provider, or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.

2. **PAYMENT FOR SERVICES:** The undersigned understands that payment is expected at the time of service for all Services. Insurance will be filed for services rendered. Patients with Medicare, Medicaid, and other Managed Care Contracts with whom we have agreements will be honored for all visits. CO-PAYS are expected at the time of service.

3. **LIABILITY CLAIMS:** Assistance will be given to provide the patient with necessary forms for filing, but payment is expected at the time of service.

4. **MEDICAL RECORDS RELEASE:** The Patient or the guarantor of the account hereby authorizes Provider to release Patient's medical record (including any information furnished Provider or obtained by Provider in connection with Patient's treatment) to any referring physician, insurance company, health care facility or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

5. **MEDICAL INSURANCE BENEFITS:** The undersigned, hereby assigns to Provider all private medical insurance benefits (primary, secondary and medi-gap providers) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

6. **MEDICARE AND MEDICAID AUTHORIZATION:** I certify that the information given by me in applying for payment under TITLES XVII AND IXIX of the Social Security Act is correct and I request payment of authorized benefits to be made in my behalf. I authorize Provider to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treat to the utilization and quality control peer review organization responsible for reviewing the medical care furnished to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/or Medicaid.

7. **FINANCIAL RESPONSIBILITY:** I acknowledge full responsibility for Services rendered and agree to make definite financial arrangements for payment. I understand that the charges made for the Services may not be covered in full by my health insurance and therefore I am solely responsible for payment of all uncovered Services. I further request that payment be made directly to "Provider" according to assignment of benefits. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred. I understand there will be a charge of $20 for any returned checks.

8. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:** By signing this form you acknowledge that you have been offered and/or are in receipt of the Notice of Privacy Practices.

_____ _____

Guarantor/Patient Signature Date

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Financial Policy

Thank you for choosing Orthopedic Physical Therapy Specialists, LLC as your physical therapy provider. We will work closely with you and your physician to provide you with successful treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship.

Our Financial Policy is as stated:

- All co-pays and deductibles are due at the time of service.
- Payment is due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss this with our Front Office Coordinator.
- We accept cash, checks, or credit cards.
- If any portion of your account balance exceeds 60 days you will be responsible for this amount.

INSURANCE

We accept Medicare, all major insurance and numerous PPO and managed care contracts. Please be aware that some, and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Orthopedic Physical Therapy Specialists, LLC will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of benefits. If this occurs, you will be responsible to pay all fees. If you need assistance in obtaining a referral, please ask our Front Office Coordinator. If payment arrangements have not been made or full payment is not received in 60 days from the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred.

Please be advised that if you are paying by check, we charge a $20 fee for returned checks.

Thank you for understanding our financial policies. If you have any questions or concerns, our Front Office Coordinator will be happy to discuss them with you.

I have read the above policies and agree to them. I authorize Orthopedic Physical Therapy Specialists, LLC to provide me with physical therapy services and to furnish information to my insurance company, worker's compensation carrier or attorney concerning my injury and treatment. I understand that I am financially responsible for payment of all services not covered by my insurance carrier.

I authorize payment of benefits directly to Orthopedic Physical Therapy Specialists, LLC for services provided.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____

THERAPIST SIGNATURE DATE

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Orthopedic Physical Therapy Specialists, LLC

Falls Efficacy Scale

Name_____

Date_____

On a scale of 1 to 10, ***with 1 being very confident and 10 being not confident at all***, how confident are you that you do the following activities without falling?

Activity

1. Take a bath or shower…….._____
2. Reach into cabinets or closets……_____
3. Walk around the house……_____
4. Prepare meals not requiring carrying heavy or hot objects……_____
5. Get in and out of bed…….._____
6. Answer the door or telephone……_____
7. Get in and out of a chair…….._____
8. Getting dressed and undressed…….._____
9. Personal grooming (i.e. washing your face)…….._____
10. Getting on and off of the toilet…….._____

Total Score……_____