PATIENT REGISTRATION

Patient's Name______________________________ Driver's License # ____________________

Custodial Parent/Guardian______________________________ Lives with ☐ Mother ☐ Father ☐ Other______________

SSN__________________________ Birth date________________ Sex: ☐ Male ☐ Female Marital Status________________

Address____

City State Zip code

Home Phone__________________ Cell Phone____________________ Email Address______________________________

Patient's Employer____ Work Phone____

GUARANTOR INFORMATION *(PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE)*

Name____ Relationship to Patient:________________________________

Guarantor's Date of Birth: ____________________ Home Phone _____________________ Work Phone____________________

Address____

City State Zip code

Employer________________________________ Employer's Address____

PRIMARY & SECONDARY INSURANCE

1) Insurance Company's Name____ Effective Date__________________

Subscriber's Name_________________________ Subscriber's D.O.B. ______________ Subscriber's SSN____________________

Subscriber's Employer______________________________ Subscriber's Group & Policy # ______________________________

2) Insurance Company's Name____ Effective Date__________________

Subscriber's Name_________________________ Subscriber's D.O.B. ______________ Subscriber's SSN____________________

Subscriber's Employer______________________________ Subscriber's Group & Policy # ______________________________

3) Other Insurance:____

INJURY INFORMATION

Date of Injury: __________________________

Was this a Work Related Injury? L&I ☐ Yes ☐ No

Was this a Motor Vehicle Accident? MVA ☐ Yes ☐ No

Cause:____

Case Manager Name:____________________________________ Case Manager Phone:_________________________________

Vocational Counselor/Nurse Case Manager:____

EMERGENCY CONTACT

____

Name Relationship Phone (Day & Night)

____

Address City State Zip code

Primary Care Physician ____ Phone ________________________________

REFERRED TO THIS OFFICE BY ____

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I authorize the doctor or the insurance company to release information required to process the claim or provide continuity of care.

Patient or Guarantor Signature: ____ Date: ________________________

Please Print Patient/Guarantor Name: ____

OLYMPIC SPORTS & SPINE REHABILITATION

MEDICAL PROFILE QUESTIONNAIRE

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. Your input is very important.

Last Name: ___________________________ First Name:_________________________ Middle Initial: _______

Age: ______ Height: _______ Weight: ________ Gender: ☐ Male ☐ Female Occupation: ____________________

Date of Onset: _________________ Description of injury/illness: ____

Onset due to: ____

Onset speed: ☐ Gradual ☐ Sudden Recent symptom trend: ☐ Better ☐ Worse ☐ No Change

Diagnostic Testing Completed: ☐x-ray ☐MRI ☐CT Scan ☐Bone Scan ☐Bone density ☐EMG/NCV ☐Blood work

Primary symptoms: ____

Do you have any of the following? (*Check all that apply)*

☐ Tingling or changes in sensation in both arms or both legs
☐ Numbness or tingling around the lips or tongue
☐ Loss of balance without loss of consciousness which causes a fall (Drop Attack)
☐ Dizziness or Vertigo
☐ Facial numbness or tingling
☐ Difficulty with bowel or bladder

PAIN

Location of Pain: ____

Does pain radiate (travel)? ☐ Yes ☐ No If yes, where: ____.

Pain Frequency: ☐ Constant/Steady ☐ Constant/Variable ☐ Intermittent Daily ☐ Occasional (less than daily) ☐ Sporadic (less than weekly)

Pain is aggravated with the following activities or positions: *(Please check all that apply)*

☐Arm and hand activities
☐Ascending stairs
☐Bending
☐Climbing ladders
☐Computer use
☐Crawling
☐Crouching
☐Descending stairs
☐Driving
☐Kneeling
☐Lying on left side
☐Lying on right side
☐Lying on stomach
☐Lying on back
☐Overhead activity
☐Pinching and grasping
☐Quick movements of the head and neck
☐Reaching
☐Sitting
☐Squatting
☐Standing
☐Walking
☐Work Activities

Pain is alleviated by: *(Please check all that apply)*

☐Bending
☐Heat
☐Ice
☐Kneeling
☐Lying on left side
☐Lying on right side
☐Lying on stomach
☐Lying on back
☐Massage
☐Medication
☐Movement
☐Rest
☐Sitting
☐Standing
☐Walking

Pain Quality: ☐ Aching ☐ Burning ☐ Stabbing ☐ Dull ☐ Pulsing ☐ Sharp ☐ Throbbing

Pain response to time of day: ☐ Better in AM ☐ Better mid-day ☐ Better in evening ☐ Worse in AM ☐ Worse mid-day ☐ Worse in evening

Any prior episodes of this problem? ☐ Yes ☐ No Explain: ____

Any problem sleeping due to the current problem? ☐ Yes ☐ No

If yes, how many times are you waking during the night? ___________

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

MEDICATIONS *(Please check all that apply)*

☐ Over-the-counter pain medications
☐ Prescription pain medications
☐ Anxiety medication
☐ Antibiotics
☐ Medication for depression
☐ Medication for high blood pressure
☐ Heart medication
☐ Medication for high cholesterol
☐ Corticosteroids
☐ Decongestants
☐ Hormones
☐ Muscles relaxants
☐ Aspirin/NSAIDS
☐ Vitamins
☐ Other: *Please list* ____
☐ *See list included in chart.*

Do you currently have or have a history of: *(Please check all that apply)*

☐Allergies
☐Asthma
☐Black outs
☐Bowel or bladder problems
☐Bruising easily
☐Cancer or Tumors
☐Coronary artery disease
☐Diabetes
☐Dizziness
☐Epilepsy or seizures
☐Fatigue
☐Frequent falls
☐Fever
☐Headaches
☐Hearing problems
☐Heart problems
☐High blood pressure
☐Infection
☐Night Sweats
☐Nitroglycerine patch
☐Osteoporosis
☐Pacemaker
☐Poor circulation
☐Smoking/Tobacco use
☐Thyroid problem
☐Unexplained weight gain
☐Unexplained weight loss
☐Visual Problems

Dominant Hand: ☐ Right ☐ Left

Previous treatment for the current problem: *(Please check all that apply)*
☐Physical Therapy ☐Occupational Therapy ☐Massage Therapy ☐Chiropractic ☐ Cortisone shot
☐Other: ____

FEMALES – Within the past twelve months have you had:
Mammogram ☐ Yes ☐ No
Breast exam ☐ Yes ☐ No
Pelvic exam ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ Possibly

MALES – Within the past twelve months have you had:
Prostate exam ☐ Yes ☐ No
Testicular exam ☐ Yes ☐ No

LIFESTYLE

Are you: ☐ Generally sedentary ☐ Physically active Have you been able to continue?___________________________

Alcohol use: ☐ None ☐ Special occasions only
☐ 2 drinks or less per day ☐ 4 drinks or less per day ☐ 6 or less drinks per day ☐ 6 drinks or more

Smoking/Tobacco use: ☐ Yes ☐ No If yes, how much? ____

Previous surgical history/date(s):____

PRIOR FUNCTION

Before this injury or episode: *(Please check the appropriate statements)*
☐ I was totally independent.
☐ I needed no help with activities of daily living (ADLs).
☐ I needed help in performing the following: ____
☐ I participated in the following sports/activities: ____

EMPLOYMENT

☐ Working full time as: ______________________________

☐ Working part time as: ______________________________

☐ Working light duty as: ______________________________

☐ Working normal duty: ______________________________

☐ Unable to work   Last date worked: ____________________

CURRENT FUNCTIONAL LIMITATIONS

I now have difficulty performing the following tasks due to the current injury/illness:

#1.______________________________

#2.______________________________

#3.______________________________

#4.______________________________

MY PHYSICAL THERAPY GOALS ARE:

#1.______________________________

#2.______________________________

#3.______________________________

PAIN RATING

Rate your pain on a scale from 0 – 10.
0 = No Pain……. increasing to 10 which is the WORST PAIN you can imagine.

Your pain today is…………………… ____________ .

The best it has been since the injury. ____________ .

The worst it has been since the injury.. ___________ .

Pain Localization: Draw the painful areas on the body diagram

0-10 Numeric Pain Intensity Scale*

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

Please mark a line on the scale above to indicate your current pain level.

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to Olympic Sports and Spine Rehabilitation to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. I also authorize Olympic Sports & Spine Rehabilitation to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered. The information provided is accurate to the best of my knowledge.

Signature: ______________________________ Date: ______/_______/_______

(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER AGE 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

Clinic Policy and Financial Agreement

Insurance Rebilling Fee Policy

It is the patient's responsibility to provide us with the correct billing information. This needs to include all information such as, work related injuries, auto accidents, third party claims, and any attorney involvement. **If you provide us with inaccurate information you will be charged a $125 rebilling fee. This charge is your responsibility and cannot be billed to an insurance carrier.**

No Show & Cancellation Fee Policy

If you should need to cancel an appointment with Olympic Sports & Spine Rehabilitation we require notice at least 24 hours before your scheduled appointment time.

I understand that if I no show or cancel an appointment without at least 24 hours advance notice a $50.00 fee will be applied to my account. I understand that I am personally responsible for payment of this fee and my insurance company will not be responsible for payment of this fee. Reasonable consideration will be given for unforeseen emergencies or illness.

Three cancelled and/or missed appointments without prior notification may result in my discharge from therapy with Olympic Sports & Spine Rehabilitation. I understand that my physician and/or claims manager will be contacted should this occur.

By reducing missed appointments we are able to offer a higher level of service and improved access to therapy for our patients. Thank you for your assistance

Financial Policy

A medical insurance policy is a contract between you and your insurance company. Your insurance company determines the amount you are responsible to pay based on your coverage plan. These amounts will be shown on the Explanation of Benefits you will receive from your insurance company. OSSR is contracted with most insurance companies and as a service to patients we agree to submit your bills directly to them. In order for us to bill your insurance company, we will ask for a copy of your insurance card.

All patient co-payments and deductibles are due at time of treatment. I understand that if I do not provide payment for co-payments at the time of each visit, my account is subject to a $5.00 administrative fee. I choose to be billed for my co-payment with a $5.00 administrative fee if not paid at the time of service.

Please remember that when you receive our statements, you have already received quality health care from our therapists. Prompt payment upon receiving your statement is appreciated. We accept Cash, Check, Visa, and MasterCard at your convenience.

Motor Vehicle Collisions

We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements until the time of settlement, judgment, or payment by attorney or the automobile insurance company.

Department of Labor and Industries

Medical expenses resulting from my workplace injury or disease will be paid by the workers' compensation program on an approved claim. However, if my claim is denied for any reason, I understand that I will be fully responsible for the total cost of my care with Olympic Sports & Spine Rehabilitation.

I understand that the *No Show & Cancellation Fee Policy* also applies to me as a Labor & Industries client. I understand that I am responsible for payment of this $50.00 fee if I do not give at least 24 hours notice prior to cancelling my appointment or if I no show for my appointment.

In consideration of physical and/or occupational therapy services rendered to the patient noted below, I understand the Claims Reprocessing Fee and the No Show and Cancellation Fee policy. I also agree to pay all amounts due which are not paid by insurance on this account.

Date **Patient Name** **Signature of Patient or Guardian**

MEDICATION LIST

Patient Name:

Date:

Referring Practitioner:

Please list ALL medications (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

MEDICATION	DOSAGE	TIMES PER DAY	ROUTE (how taken) Oral, Injection, etc.
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

This information has been reviewed with the patient (or authorized representative) to confirm accuracy.

Patient's Signature: Therapist Initials:

Notice of Privacy Practices & Communication Acknowledgement

I,_____________________________________, (patient's name) understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This organization reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revision notice to the address I've provided if requested.

Our organization may contact you to remind you of any appointments, healthcare treatment options, billing concerns, or other health services that may be of interest to you.

May we contact you at home? ☐ Yes ☐ No Phone: _________________________________ OK to leave a message? ☐ Yes ☐ No

May we contact you at Work? ☐ Yes ☐ No Phone: _________________________________ OK to leave a message? ☐ Yes ☐ No

May we contact you by cell? ☐ Yes ☐ No Phone: ___________________________________ OK to leave a message? ☐ Yes ☐ No

Would you like to receive a reminder of your appointment by email or text? ☐ Yes ☐ No If yes, complete the information below:

Email address: _____________________________________ Cell phone provider (ex. Verizon, AT&T): ___________________________

Additional Comment: ____

Is there anyone we can leave a message with? ☐ Yes ☐ No (If yes, list their full name and relationship to you below)

____ ______________________________________
(Name) (Relationship)

____ ______________________________________
(Name) (Relationship)

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. ☐ Yes ☐ No (If yes, list their full name and relationship to you below)

____ ______________________________________
(Name) (Relationship)

This authorization will remain in effect until revoked in writing. Copies of your chart or any other written information are not covered by this authorization.

____ ______________________________________
Signature of Patient or Legal Guardian **Date**

____ ______________________________________
Printed Name of Patient or Legal Guardian **Relationship**

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ Patient refused to sign
☐ Communication barrier prohibited obtaining the acknowledgement
☐ An Emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify):____

____ ______________________________________
Employee Signature Date