Tempe
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Tempe, AZ 85282
(P) 480-921-9000

Ahwatukee
4302 E Ray Rd Ste 105
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(P) 480-597-4241

Biltmore
6245 N 24th Pkwy #105
Phoenix, AZ 85016
(P) 602-997-7844

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Patient Name:	
Date of Birth:	**Today's Date:**
Address (street, city, zip):	
Home Phone:	**Cell Phone:**
Email:	
May we contact you via text and/or email regarding your treatment? *(circle one)* **Your preferred method of contact:** **text** **email**	
Emergency Contact: *(name, phone number and relationship to patient)*	

How did you hear about Orthopedic Sports Therapy?

Google	Yelp	Mailed postcard	Social media	Our website
Zocdoc	YouTube	I am a previous patient	Other:	
Doctor:	Name of the Doctor?			
Word of mouth:	Whom can we thank?			

OST offers a personal training program that is supplementary to your physical therapy treatment: **OST Athletics**, a hybrid (in person and online) personal training program. *Are you interested in OST Athletics?*

OST Athletics	Yes	Maybe later	No

New Patient Health Questionnaire

Patient Name: _____ Date: _____

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and I have the right to question and/or refuse any treatment offered.

_____

Patient signature or guardian if patient is a minor

Do you have any barriers to learning? Yes/No
If yes, please list: _____

Gender: *M/F/X*	Age:	Pregnant: *Y N*	Smoker: *Y N*
Occupation:		Do you exercise at least 3 days/week? *Y N*	
Past Surgical or hospitalization dates (list & date):			
Current medications: *(dosage and condition it is for)*			
Where are your symptoms?			
When did your current symptoms start? mm/dd/year:			
Did your current symptoms start: (circle)	*Gradually*	*Suddenly*	*Due to injury/accident*
My symptoms are: (circle)	*Improving*	*Unchanging*	*Worsening*
What treatments have you received for this problem so far?			
What makes your symptoms better?			
What makes your symptoms worse?			
Have you had Xray, MRI, or other imaging study for this problem?			Y/N
If yes, what kind and what were the results:			

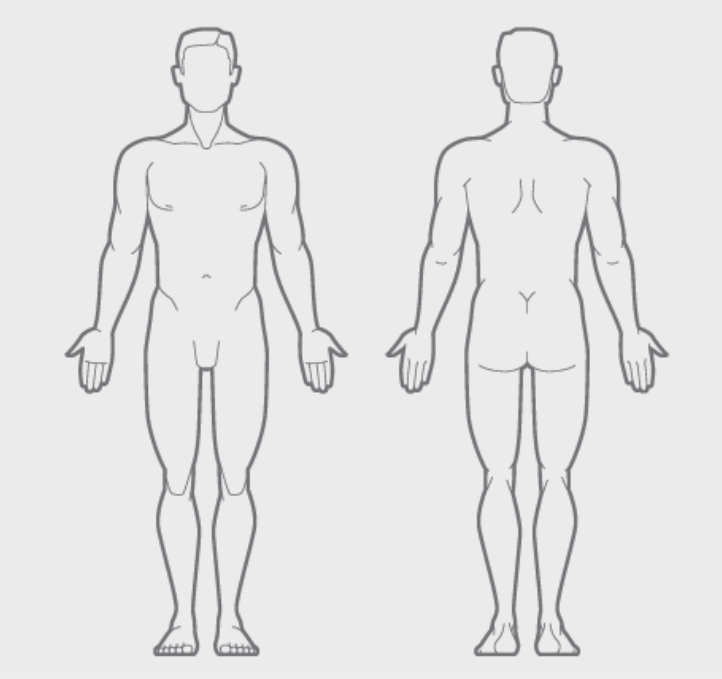
CURRENTLY or recently, I am experiencing: *mark Yes or No*

	Y/N		Y/N		Y/N
Fever/sweats		Poor balance or falls		Numbness or Tingling	
Fatigue		Difficulty Swallowing		Shortness of breath	
Nausea/vomiting		Dizziness		Heartburn/indigestion	
Headaches		Increased pain at night		Confusion	
Depression		Weakness		Fainting	
Unexplained weight loss		Changes in bowel or bladder function		Changes in appetite	

Have you had any of the following in the PAST: *mark Yes or No*							
	Y/N		Y/N		Y/N		Y/N
Cancer		Diabetes		Hepatitis		Liver disease	
Allergies		Ulcers		Fibromyalgia		Lung disease	
Osteoporosis		Heart disease		Osteoarthritis		Asthma	
Angina or Chest pain		Rheumatoid Arthritis		Sexually Transmitted disease		Bladder or Urinary tract infection	
Blood disorders or clots		Bone or joint infection		Chemical dependency		Stomach problems	
Stroke		Epilepsy		Eye problems or infection		Kidney disease or infection	
Past Medical History Details:							
Other medical conditions, not listed:							
How would you rate your **OVERALL health** on a 0-10 scale? *poor-excellent*							
poor 0 1 2 3 4 5 6 7 8 9 10 *excellent*							
FAMILY: Has anyone in your immediate family ever had any of the following: *Mark Y or N*							
	Y/N		Y/N		Y/N		Y/N
Diabetes		Cancer		Stroke		Tuberculosis	
High blood pressure		Heart problems		Blood disorders or clots		Thyroid problems	
Other immediate family medical issues:							

Have you ever taken blood thinners?			*Y N*
Have you ever taken steroids? (for medical or fitness reasons)			*Y N*
Have you ever used performance enhancing drugs or supplements?			*Y N*
Are you allergic to latex or adhesives?			*Y N*
Have you had a recent illness?			*Y N*
If so, describe:			
Does eating aggravate your symptoms?			*Y N*
Does taking a deep breath aggravate your symptoms?			*Y N*
How are you able to sleep at night: (circle)	*Fine*	*Moderate difficulty*	*Only with medication*
During the past month, have you often been bothered by feeling down, depressed or hopeless?			*Y N*
During the past month, have you often been bothered by a lack of interest or pleasure in doing things?			*Y N*
If yes to either of the previous 2 questions, is this something for which you would like help?	*No*	*Yes, but not today*	*Yes*
How would you describe your stress level?	*Low*	*Moderate*	*High*

Mark your area(s) of symptoms or pain:



Circle your pain levels over the past 48 hours:												
	None	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10* *terrible*
Current pain		*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Worst pain		*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Least pain		*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Average level of pain		*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Circle the number that best represents your current average level of function:										
Able to do everything	1	2	3	4	5	6	7	8	9	10	Cannot do anything

Identify activities that you are unable to do or are having difficulty with as a result of your problem.
1.)
2.)
3.)
What are YOUR GOALS for physical therapy at this time?

Patient or Guardian Signature: _____

Same Day Cancellation (within 24 hours)

and/or

Missed Appointment

$90 Fee

OST realized that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, 24-hour advanced notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our one-on-one treatments, missed appointments have a significant impact on your physical therapy, the clinic, and other patients.

1) This fee is required to be paid prior to your next scheduled appointment.

2) Workman's Compensation carriers require providers to report regularly missed appointments. Should this occur, your claim status may be affected.

3) After missing two appointments without proper notice, you may be placed on a same day scheduling basis or required to prepay for services at the time of scheduling in order for OST to hold your appointment.

4) Before 8 am and after 4 pm are the high-demand appointment times. Should you miss two appointments without proper notice, you may be required to change the time of future appointments to hours outside the high demand time.

Thank you for your understanding and cooperation. Signing below indicates that you understand and agree to the terms of this policy.

Patient/Caregiver_____ Date_____

Patient Name:	Date of Birth:

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Orthopedic Sports Therapy. I permit its employees and all other appropriate persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and related services at Orthopedic Sports Therapy. I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Orthopedic Sports Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Orthopedic Sports Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Initial: _____

Assignment of Benefits

I authorize payment directly to Orthopedic Sports Therapy for services and to bill and release payment directly to Orthopedic Sports Therapy, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

The Notice of Privacy Practices (HIPAA) for Orthopedic Sports Therapy is available to the patient upon request. I hereby acknowledge a copy of the Notice of Privacy Practices of Orthopedic Sports Therapy is available to me. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

Initial _____

Payment Guarantee

I agree to pay Orthopedic Sports Therapy for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Orthopedic Sports Therapy.

Initial _____

Note: If a patient account is 60 days overdue the patient will be notified in writing that the patient has 15 days to pay in full. A second letter will be sent within 15 days if the balance remains unpaid. Be aware that if a balance remains unpaid we may refer the patient's account to a collection agency. Any collection agency fees or costs will be added to the outstanding balance and the patient will be responsible for the collection agency fees.

Initial _____

Patient Information & Data Sheet

I hereby acknowledge that the information I provided on the Intake Form and the Patient Data Sheet is correct.

Initial _____

Patient or Guardian Signature:	**Date:**