Orthopedic Associates of SW Ohio

www.oaswo.com 1-800-824-9861

THE SPINE CENTER OF SOUTHWEST OHIO

THE HAND CENTER OF SOUTHWESTERN OHIO

Physical and Occupational Therapy

Patient Medical History Form

PATIENT NAME____ DOB____________________

ADDRESS________________________________ CITY, ST, ZIP____________________________

PHONE # __________________ WORK # __________________ CELL # ____________________

EMERGENCY CONTACT______________________________ PHONE # ______________________

PRIMARY CARE PHYSICIAN_________________________ DATE OF NEXT APPT ___________________

REFERRING PHYSICIAN____________________________ DATE OF NEXT APPT___________________

CAUSE OF INJURY OR ONSET _______________ ARE YOU PRESENTLY WORKING? Y N

OCCUPATION___________________ JOB DEMANDS__________________________________

DATE OF SURGERY___________________ HAND DOMINANCE: LEFT or RIGHT

PLEASE CHECK ALL THAT APPLY TO YOU

SMOKER_____ PACEMAKER/DEFIBRILLATOR_____ CANCER_____ DIABETES_____ HEART ATTACK_____

HEART SURGERY_____ LUNG DISEASE_____ SHORT OF BREATH_____ HIGH/LOW BLOOD PRESSURE_____

BOWEL/BLADDER DYSFUNCTION_____ RECENT WEIGHT LOSS/GAIN_____ NEUROLOGICAL DISORDER_____

STROKE_____ METAL IMPLANTS_____ ALLERGIES_______________ OTHER______________________

MEDICATIONS____

PRESENT CONDITION

CURRENTLY SEEKING THERAPY FOR?____

WORK RELATED? Y N IF NOT, TYPE OF INSURANCE COVERAGE?_____________________________

ANY PREVIOUS TREATMENT FOR THIS CONDITION? Y N WHEN AND # OF TREATMENTS _________________

ARE YOU CURRENTLY REVEIBING HOME HEALTHCARE, OR PHYSICIAL THERAPY FROM ANY OTHER FACILITY? Y N

WHERE______________________________ WHEN____________

ANY DIAGNOSTIC TESTING FOR THIS CONDITION? (CIRCLE) X-RAY CT SCAN MRI EMG BONE SCAN

WHERE_________________________________ WHEN_________________________________

DO YOU USE ANY BRACES OR SUPPORTS? Y N IF SO, WHAT KIND?___________________________

DO YOU NEED ASSISTANCE WITH ACTIVITIES AT HOME? Y N WHAT TASKS?______________________

REVIEWED BY THERAPIST____ DATE________________

REVIEWED BY THERAPIST____ DATE________________

REVIEWED BY THERAPIST____ DATE________________

REVIEWED BY THERAPIST____ DATE________________

AUTHORIZATION FOR TREATMENT

I THE UNDERSIGNED CONSENT TO AND AUTHORIZE TREATMENT WHICH MAY BE CONSIDERED ADVISABLE BY THE ATTENDING PHYSICIAN OR THEIR DESIGNATES. I ACKNOWLEDGE NO GUARANTEES HAVE BEEN MADE AS TO THE RESULTS OF TREATMENTS.

____ ________________________________

SIGNATURE OF RESPONSIBLE PARTY DATE

FINANCIAL AGREEMENT

ALL CHARGES ARE MY RESPONSIBILITY, I ASSIGN AND AUTHORIZE PAYMENT FOR SERVICES RENDERED TO BE MADE DIRECTLY TO ORTHOPEDIC ASSOCIATES OF SOUTHWESTERN OH, INC. OF ALL INSURANCE BENEFITS AND AGREE TO PAY ANY SELF-PAY, DEDUCTIBLE OR CO-INSURANCE BALANCE DUE.

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION IN REFERENCE TO ME, TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENT, ANY INFORMATION NEEDED IN DETERMINING THOSE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH TO ORTHOPEDIC ASSOCIATES OF SOUTHWESTERN OHIO, INC. ANY INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVII OF THE SOCIAL SECURTIY ACT.

____ ________________________________

SIGNATURE OF RESPONSIBLE PARTY DATE

THERAPY

CANCELLATION/NO SHOW/ TARDY POLICY

TARDY PATIENTS:

If a patient arrives for their scheduled appointment more than 15 minutes late, therapy check in will notify PT/OT before the patient is allowed to proceed back to the gym. If therapist deems it necessary, patient will be asked to rescheduled, and documentation of the incident will be made in patient's PT/OT chart.

Cancel/No Show Patients:

If a patient No Shows for an appointment, there will be a $50 fee which must be paid before the patient can reschedule. If patient demonstrates a pattern of repeated cancellations with or without valid cause and cancellations are deemed excessive, patient may be discharged from therapy at the discretion of the evaluating therapist, and patient's physician will be notified.

I have read and understand the above policy.

Patient's Signature: ______________________________ **Date**________________