ORTHOHEALING
CENTER

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NON-SURGICAL ORTHOPAEDICS AND SPORTS MEDICINE

Name:______________________________ Today's Date: ______/_____/_______ Age:_____

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST THE DOCTORS IN DEVELOPING AN INDIVIDUALIZED PLAN OF CARE FOR YOU. THIS INFORMATION IS CONFIDENTIAL.

Medical History**:** (*Diabetes, high blood pressure, asthma etc*) ____

Surgical History: ____

Current Medications: ____

Allergies:____

PLEASE PROVIDE A DETAILED DESCRIPTION OF YOUR REASON FOR SEEKING TREATMENT:

____

____

____

HOW LONG HAVE YOU HAD THIS PROBLEM? ____

PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET
PLEASE CIRCLE: IMPROVING PAIN WORSENING PAIN

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE:

0 1 2 3 4 5 6 7 8 9 10
(no pain) (severe pain)

IS YOUR PAIN CONSTANT OR INTERMITTENT? (*circle one*)

HOW WOULD YOU DESCRIBE THE PAIN? Circle one: *sharp dull achy electric:*__________________

WHAT MAKES YOUR PAIN WORSE? ____

WHAT HELPS ALLEVIATE YOUR PAIN? ____

DOES THE PAIN RADIATE TO ANY OTHER PART OF YOUR BODY? __________________________

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?
_____ No other treatment _____ Massage therapy ____ Chiropractor
_____ Physical therapy _____ Acupuncture ____ Other: ___________________________
_____ Epidural Spinal Injection _____ Surgery
_____ Medications (Please list) ____

HAVE YOU HAD ANY OF THE FOLLOWING EXAMS RECENTLY? (CIRCLE ALL THAT APPLY)
MRI X-RAY CT SCAN EMG (Nerve test) IF SO, WHEN: _____________________________
Please bring **reports** of any imaging studies that you've had related to your chief complaint

OCCUPATION:____

HOBBIES:____

Height_______ Weight_________

MARITAL STATUS (CIRCLE ONE):
Single Live with Partner Married Separated Divorced Widowed

DO YOU CONSUME ALCOHOLIC BEVERAGES? (CIRCLE ONE)
NEVER RARELY MODERATLEY DAILY

DO YOU SMOKE CIGARETTES? YES NO PACKS PER DAY_________YEARS SMOKED__________

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? (CIRCLE ONE) YES NO N/A

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

	YES	NO		YES	NO
General weakness			Abnormal bowel movements		
Leg Cramping			Frequent urination		
Numbness			Unable to urinate		
Shortness of breath			High blood pressure		
Swelling of hands, feet or ankles			Chest pain or angina		
Weakness of muscles or joints			Stroke		
Any difficulty walking			Heart surgery		
Pain in calves or buttocks			Heart disease		
If yes, is that pain relieved by rest?			Cardiovascular disease		
History of falls or poor balance			Epilepsy/Seizures		
Decreased sensation in arms or legs			Kidney disease		
Numbness in arms or legs			Lung disease		
Psychiatric care			Fevers		
Depression			Emphysema/Bronchitis		
Chemical dependency (alcohol/drugs)			Gout		
Hepatitis			Arthritis		
Weight Loss			Diabetes		
Thyroid problems			Varicose Veins		
Dizziness/Fainting			Irritable Bowel Syndrome		
Cancer			Stomach Ulcer		
Family history of cancer Please Specify: _______________ _______________________________			Disruption in sleeping habits		
Hearing Loss					

IS THERE ANY OTHER CONDITION YOU WOULD LIKE TO TELL THE DOCTOR ABOUT?

____

Please sign below to confirm that the information presented in this questionnaire is accurate:

Signature: ____________________________

Patient Name: ______________________ Date: _________________

Cancellation/No Show Policy

Dear Patient,

In order to promote timely office visits and enhance patient care, there will be a cancellation and a no show fee. If you need to reschedule or cancel your appointment, please do so at least 24 hours prior to your appointment time. If a follow up appointment is not cancelled or rescheduled 24 hours in advance, you will be charged a fee of $50. If an injection or other type of procedure is not cancelled or rescheduled 24 hours in advance, you will be charged a fee of $100. If you fail to show up for an appointment, you will be charged $50.

Thank you for your cooperation.

Sincerely,

The Orthohealing Center.

I have read the cancellation policy and understand that I am responsible for any charges made to me for not cancelling or rescheduling an appointment 24 hours prior to the scheduled time.

____

Patient Name (Please Print)

___________________________________ ___________________

Patient Signature Date

Financial Policy

Thank you for choosing The Orthohealing Center as your provider. We will work diligently 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 service 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. The Orthohealing Center 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 will charge a $20 fee for returned checks.

Thank you for understanding our financial policies. If you have any question 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 The Orthohealing Center to provide me with services and to furnish information to my insurance company, worker's comp 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 <u>The Orthohealing Center</u> for services provided.

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Signature of Patient or Responsible Party　　　　　　　　　　　Date

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The Orthohealing Center　　　　　　　　　　　　　　　　　　　Date