



PATIENT INFORMATION			EMAIL ADDRESS: _____		
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #: - -		
Home Phone: ( ) -		Alternative Phone (Cell, Pager): ( ) -		Spouse:	
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.:			<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:					
WORK INFORMATION					
Employer:			Work Phone ( ) -		Ext.
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed			
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: ( ) -		
Regular Dr./PCP			Regular Dr./PCP Phone: ( ) -		
INSURANCE INFORMATION ( PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST )					
Primary Insurance Name:					
Subscriber's Name (If different):				Birth date: / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:				Birth date: / /	
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM ( PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP )					
Insurance Name: <input type="checkbox"/> Auto :			<input type="checkbox"/> Labor & Industries:		
Adjuster/Claim Manager:			Phone:		Ext.:
Address:		City:	State:	Zip:	
Claim #:	Accident Date: / /		Cause:		
ATTORNEY INFORMATION					
Name:		Law Firm:		Phone: ( ) -	
Address		City:	State:	Zip:	
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: ( ) -		Work Phone: ( ) -	

I authorize my insurance benefits be paid directly to Applied Ortho Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Applied Ortho Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE

DATE

# PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Diabetes		
	YES	NO		YES	NO
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other: _____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : \_\_\_\_\_

What things cause stress in your life? : \_\_\_\_\_

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative \_\_\_\_\_

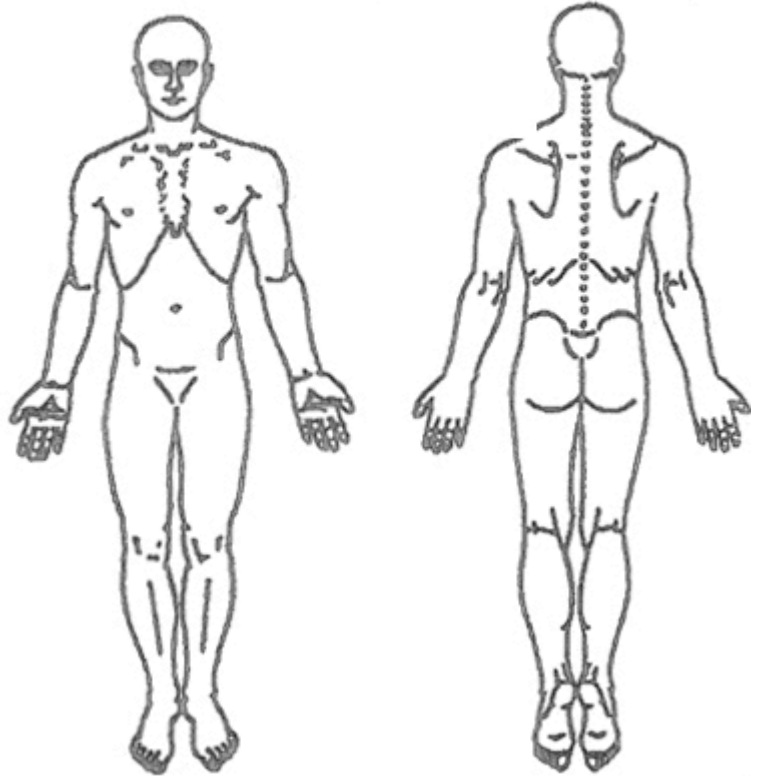
Date \_\_\_\_\_

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



Ache  
MMM  
M

Burning  
— — —  
— —

Numbness  
O O O O  
O O O

Pins and Needles  
□ □ □ □ □ □ □ □ □ □  
□ □ □ □ □ □ □ □ □ □

Stabbing  
/ / / / / / / /  
/ / / /

Other  
x x x x  
x x x

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

Please circle on the scale below to indicate your **CURRENT** level of pain:

No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.

Please circle on the scale below to indicate your **AVERAGE** level of pain:

No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.

Please circle on the scale below to indicate your **WORST** level of pain:

No Pain    0    1    2    3    4    5    6    7    8    9    10    Pain as bad as it gets.

Additional Comments \_\_\_\_\_

# Assignment of Benefits to AppliedOrtho Physical Therapy

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Your relationship to the Insured:  Parent  Spouse  Other: \_\_\_\_\_

Claim # \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to:

**AppliedOrtho Physical Therapy**  
**19504 Doctors Drive**  
**Germantown, MD 20874**  
**301-515-1068**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize AppliedOrtho Physical Therapy to deposit checks made in my name.
- I authorize AppliedOrtho Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder



## **CANCELLATION/LATE APPOINTMENT POLICY**

In our efforts to offer you, our patient, ample time and attention at your appointment, we schedule one patient per session per therapist. Other clinics schedule more, assuming that some may not show up. This can cause long waits and extended time in the clinic. Since we do not practice this type of scheduling, it is important that you show up, on time, for your appointment.

There are of course occasions when you absolutely cannot make your appointment. Please call us at least **24 hours** prior to the missed appointment so that we may offer the time slot to another who needs to be seen.

Due to the cost's incurred by missed and/or late-appointments, there will be a **fee of \$25 charged for no shows and/or late-appointments** that may result in a re-scheduled appointment. Since insurance will not cover this fee, you will be responsible for payment.

I have read and understand AppliedOrtho® cancellation policy, additionally, I understand by signing below, that the fee is **NOT** covered by insurance and is my personal responsibility.

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Patient's Printed name

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Witnessed by (staff signature)

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Patient's signature

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Date

# AppliedOrtho Physical Therapy® Statement of Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method

or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (301) 515-1068. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (301) 515-1068. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide AppliedOrtho Physical Therapy® with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Facility Signature

\_\_\_\_\_  
Date