ADMISSION RECORD

FORM COMPLETION INSTRUCTIONS:

- Please answer all questions (**Please enter N/A if not applicable**)
- All information will remain strictly confidential
- Questions, please ask our office associate

Patient Name:			Patient Date of Birth	Social Security Number
Mailing Address (No. & Street, Apt., etc.)			E-Mail Address	
City	State	Zip Code	Gender: Female Male	
Home Phone Number ( )	Work Phone Number ( )		Cell Phone Number ( )	
Primary Insurance Carrier Name			Secondary Insurance Carrier Name	
Insured's relationship to you □ Self □ Parent □ Spouse □ Other			Insured's Name (Who carries insurance contract)	
Insured's Employer Name:			Insured's Employer Address:	
City	State	Zip	Employer Phone Number:	
Insured's Date Of Birth:			Emergency Contact and Phone	
Marital Status: □ Single □ Married □ Divorced □ Widowed			Your occupation:	
Spouses Name:			Spouses Date of Birth	Social Security Number
PRIMARY CARE Physician Name			Phone Number	Date of Next Office Visit
REFERRING Physician Name			Phone Number	Date of Next Office Visit
I was referred to OCPT by:				

PATIENT AUTHORIZATION AND RESPONSIBILITY

I hereby consent to treatment at Ortho Care Physical Therapy, Inc. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Ortho Care Physical Therapy, Inc. By consenting to treatment, I also consent to the release of necessary medical information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Ortho Care Physical Therapy, Inc. upon completion of the treatment session or within 10 days thereafter. I further understand that if the matter is referred to an attorney for collection, I will be responsible for the attorney's fees and court costs.

Signature of Patient, Guardian/Parent	**Date**

ORTHO CARE Physical Therapy OCPT

PATIENT MEDICAL HISTORY INFORMATION

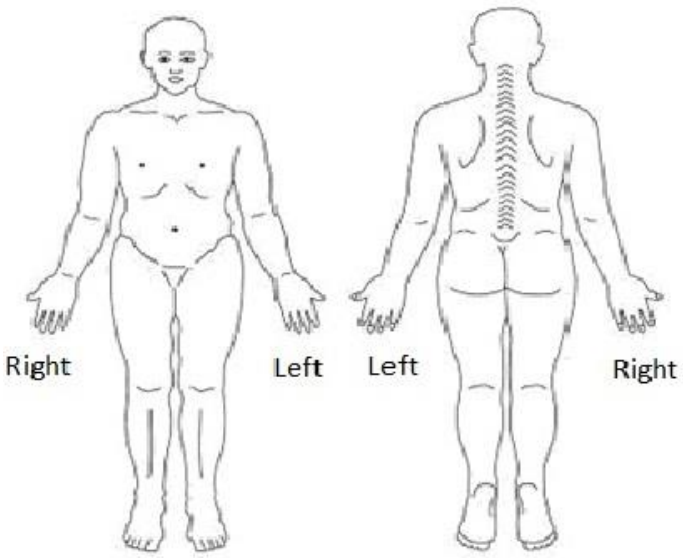
PATIENT NAME: _____

Describe Your Pain: Use this chart to help you describe your particular level of pain to your health care provider.

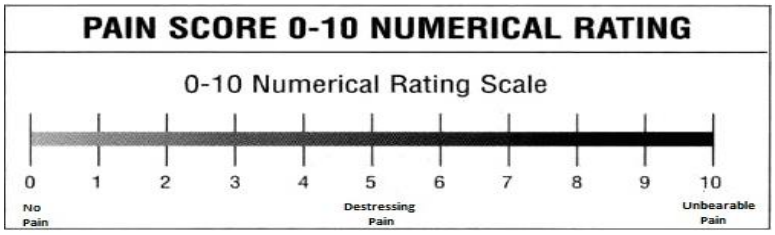
My pain is:

- ☐ Throbbing
- ☐ Stabbing
- ☐ Dull
- ☐ Aching
- ☐ Other (Please describe) _____
- ☐ Pinching
- ☐ Burning
- ☐ Steady
- ☐ Localized
- ☐ Persistent
- ☐ Comes & Goes

1. Please shade areas where you are experiencing pain.



2. Use the scale below to better estimate the level of the pain you are experiencing: Remember that pain effects everyone differently and only you know what you are feeling. The following scale can help you define the intensity of your pain and describe your discomfort to caregivers so they can provide the best treatment.



0-1: Very little or barely noticeable pain.

2-3: Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.

4-5: You now notice your pain, perhaps at rest or during activity. It may interfere with you activities. Level "4" is the level at which it is a good idea to start introducing some avenues of relief.

PATIENT MEDICAL HISTORY INFORMATION

6-7: Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be "gritting your teeth" to carry out activities.

8-9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even during rest or quiet times.

10: Your pain is now the worst you can imagine. Do not wait for "Level 10" before you discuss options with your health care provider.

3. Is your injury related to A) work, B) a motor vehicle accident, C) a recreational accident, or D) other? (Please circle appropriate answer)

4. What was the specific cause of injury, or the series of events leading up to your visit today?

Description: _____

_____

Onset of injury date? _____**Sudden** or **Gradual** (Please circle appropriate answer)

5. Describe how your symptoms progress through the day. (For example better, worse, stiff, same)

_____

6. Do you wake up during the night because of pain? ☐ Yes ☐ No How many times? _____

7. Is there any particular activity that aggravates you symptoms? _____

8. What relieves your symptoms? _____

9. Since your symptoms first started have they: (circle one) increased, decreased, or stayed the same?

10. Since your symptoms first began do you have any difficulty with or control of bladder and/or bowel function? ☐ Yes ☐ No Describe _____

11. List medications you are taking now. _____

_____

12. Please list and date any recent diagnostic tests relating to this injury (CT scan, MRI, Xray, Bone Density Scan, EMG, Cardiac Stress Test, Other) _____

13. Please list surgeries you have had. Please give procedure and dates, if possible.

_____

14. Do you exercise, and if so what do you do? _____

15. How often do you exercise? **None, Occasionally, 1-2 days/wk, 3-4 days/wk, 5 or more days/wk** (Please circle appropriate answer)

16. How would you rate your general health? **Excellent, Good, Average, Fair, Poor** (Please circle appropriate answer)

17. Do you have any metal including teeth in your body? (i.e. pins, plates, pacemaker) ☐ Yes ☐ No 18. Have you ever had physical therapy and/or Chiropractic treatments before? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY INFORMATION

If yes, please indicate which, where, when, and for what problems.

_____

19. List any allergies you have _____

20. Have you ever had the following?

High blood pressure?	☐ Yes ☐ No	Seizures?	☐ Yes ☐ No
Heart/circulation disorders?	☐ Yes ☐ No	Dizzy Spells?	☐ Yes ☐ No
Arthritis/Osteoarthritis?	☐ Yes ☐ No	Diabetes?	☐ Yes ☐ No
Immune deficiency disease?	☐ Yes ☐ No	Cancer?	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Broken Bones?	☐ Yes ☐ No

21. Have you had any recent trouble with vision? ☐ Yes ☐ No

22. Have you had any recent trouble with hearing? ☐ Yes ☐ No

23. Have you had any unusual weight gain or loss lately? ☐ Yes ☐ No

24. Do you smoke? ☐ Yes ☐ No

If yes, how many Packs/Day _____

25. Do you have an infectious disease? (ie, hepatitis, TB, HIV, shingles, etc.) ☐ Yes ☐ No

26. Have you ever taken steroids or anti-coagulants for an extended period of time? ☐ Yes ☐ No

27. For Women, are you pregnant? ☐ Yes ☐ No

28. Date of your last doctor's appointment? _____

29. Has anyone in your immediate family (parents, brothers, sisters) ever had any of the following?

☐ Cancer, ☐ High Blood Pressure, ☐ Physiological problems, ☐ Stroke, ☐ High Cholesterol,
☐ Diabetes, ☐ Arthritis, ☐ Heart Disease, ☐ Osteoporosis, ☐ Other (explain) _____

_____

Name of person completing this form (print)	Signature of Patient or Responsible Adult and Date

SOCIAL WORK/VOCATIONAL SPECIALIST REVIEW

We are interested in the total well being of our patients. In keeping with this philosophy, we feel that Social Worker/Vocational Specialist intervention may sometimes be appropriate. During your rehabilitation you, your therapist, or our Social Worker/Vocational Specialist might agree that this service may be helpful. If you check yes to the last question our Vocational Specialist will contact you to see if we can further assist you.

	Yes	No	N/A
Are you having problems with employment secondary to disability?	____	____	____
Have you applied for worker's compensation?	____	____	____
Do you feel you need job training skills?	____	____	____
Are you having difficulty completing household tasks?	____	____	____
Do you have transportation problems?	____	____	____
Is this present medical condition affecting your family relationships?	____	____	____
Do you have a history of depression/anxiety?	____	____	____
Have you seen a Psychiatrist/Counselor?	____	____	____
Do you have adequate insurance coverage?	____	____	____
Do you have prescription coverage?	____	____	____
Are you low income?	____	____	____
Have you ever applied for Medicaid?	____	____	____
Do you wish to speak to a Social Worker/Vocational Specialist?	____	____	____

If you check no at this time, but in the future are in need of services, please inform the Physical Therapist and you will be contacted for an appointment with our Social Worker/Vocational Specialist.

_____ _____

Patient Signature Date

Revised November 12, 2014

ORTHO CARE PHYSICAL THERAPY, INC.

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of the Ortho Care Physical Therapy Inc. Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Effective Date: *9/23/2013*

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.

If you have any questions about this notice, please contact: **Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066**.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you

about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066***. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066***.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066, 586-294-9030***.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066***. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066, 586-294-9030.*** Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.orthocarephysicaltherapy.com. To obtain a paper copy of this notice, ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066, 586-294-9030***.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact ***Ortho Care Physical Therapy, Inc. Attn: Administrator (Privacy Officer) 30695 Little Mack, Suite 600, 48066, 586-294-9030.*** All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

ORTHO CARE
Physical Therapy, Inc.
OCPT

30695 Little Mack
Suite 600
Roseville, MI 48066
Tel. (586) 294-9030
Fax (586) 294-9033

43455 Schoenherr Rd.
Suite 9
Sterling Heights, MI 48313
Tel. (586) 323-9030
Fax (586) 323-9032

PREVENTION AND REHABILITATION CLINIC

OCPT Cancellation and No Show Policy

Your physician has recommended physical therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments. Your therapist will advise you at your evaluation how many times a week it will be necessary for you to attend.

ALL appointments missed should be made up within the remaining time of current prescription. 3 consecutive NO SHOWS WILL RESULT IN IMMEDIATE DISCHARGE due to non-compliance and your referring physician will be notified.

Ortho Care Physical Therapy requires 24 hour notice for any cancellation. If you fail to give 24 hour advance notice for any cancellation or you do not show for your scheduled appointment an administrative fee of $25 may be applied to your account.

I, _____, have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____
Print Patient Name

_____ _____
Patient Signature Date