ARROWHEAD ORTHOPAEDICS
*PHYSICAL THERAPY*

**Welcome to Arrowhead Orthopaedics Physical Therapy, and thank you for entrusting us with your therapy and rehab.**

We are committed to your well-being, and to assisting you in achieving an optimal level of functionality and quality of life at home, at work and in leisure settings.

Therapy is a dynamic process, requiring a spirit of commitment and teamwork. Our staff will work with you and guide you throughout the process. However, it is your active involvement and participation on a consistent basis that will ensure a successful outcome.

As you are no doubt aware, insurance companies have assumed an expanded role in the provision of healthcare, including therapy services. Many of the companies limit authorization to a fixed period of time (e.g., two weeks). Others require that we notify them of cancellations and "no shows".

Missed appointments limit the progress you can expect to make, jeopardize insurance benefits and inconvenience your therapists. You can help ensure a successful outcome and protect your benefits by observing the following guidelines:

> Keep ALL scheduled appointments
>
> Never simply "no show". You may cancel in person, or by calling our office and leaving a message if no one answers. If you "no show" for an appointment, we will give you a courtesy call to reschedule. You have 24 hours to call us back and confirm your next appointment. If you fail to do so, we reserve the right to cancel your future appointments until we hear back from you. If applicable, we will also notify your adjuster(s).

Thank you in advance for you cooperation.

I am committed to the success of my therapy program and will do my part to ensure the best outcomes.

Patient Name: _____

Patient Signature: _____ Date: _____

ARROWHEAD ORTHOPAEDICS
"A Tradition of Excellence"

**CONSENT FOR MEDICAL TREATMENT**

I give consent to Arrowhead Orthopaedics (AO), its staff, physicians and other practitioners to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by Arrowhead Orthopaedics for my health and well being. This also includes treatment of a minor (under the age of 18).

**MEDICAL RECORD RELEASE**

I hereby authorize any necessary medical records, prescription history, and/or diagnostic studies be released to Arrowhead Orthopaedics for management of my care.

**NOTICE OF PRIVACY PRACTICES**

I have been provided the *Notice of Privacy Practices*, which describes the use and disclosure of my protected health information that will occur during my treatment and bill payment. This *Notice of Privacy Practices* also describes my rights and the duties of Arrowhead Orthopaedics with respect to my protected health information.

**RELEASE OF INFORMATION**

I understand that Arrowhead Orthopaedics will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to Arrowhead Orthopaedics or me for all or part of Arrowhead Orthopaedics' charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of Arrowhead Orthopaedics or a third party payor; (5) for Arrowhead Orthopaedics normal health care operations. I understand that Arrowhead Orthopaedics may communicate information including protected health information with me by phone, mail, through the AO Direct Patient Portal. I understand that to ensure continuity of care, all Arrowhead Orthopaedics' providers and staff will have access to the information in my electronic health record.

**COMMUNICATION CONSENT (Check to confirm approval of method)**

I agree to allow AO to contact me using the following method(s) regarding my personal health information, evaluation and treatment. AO is authorized to leave messages for me when I am not available as indicated below:

**Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work**

- ☐ Home Phone: ( ) _____ Messages: ☐Yes ☐No
- ☐ Cell Phone: ( ) _____ Messages: ☐Yes ☐No
- ☐ Work Phone: ( ) _____ Messages: ☐Yes ☐No
- ☐ E-mail: _____

I authorize AO and medical staff to discuss my personal health information with the individuals listed below. I understand by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone.

Name _____ Relation _____

Name _____ Relation _____

**I HEREBY AGREE WITH AND CONSENT TO ALL OF THE ABOVE.**

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Signature of Patient/Legal Representative | Date of Birth |
| _____ | _____ | _____ |
| If signed by Legal Representative (print name) | Relationship to patient | Date |

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# Physical and Occupational Therapy – Patient Intake Form

**Name: _____ Age: _____ Ht: _____ Wt: _____**

**Date of Birth : _____ Social Security Number : ____ __ _____**

Dependent children under age 5 : _____ Hand You Use: Left / Right / Both *(circle one)*

Date of Injury: _____/_____/_____ Date of Applicable Surgery: _____/_____/_____

Are you: Employed/ Modified / Unemployed / Retired / Disabled: temp/permanent *(circle one)*

Occupation: _____ Main Duties _____

Applicable Recreational Activities: _____

## HEALTH HABITS

My General Health is: Poor Fair Good Excellent *(circle one)*

My Diet is: Poor Fair Good Excellent *(circle one)*

Do you Smoke? Yes / No If Yes, how regularly? _____

Do you Drink? Yes / No If Yes, how regularly? _____

## MEDICAL HISTORY

Dates *Pertinent* Major medical events in your life (Surgeries, Accidents, Illnesses, etc)

_____ _____

_____ _____

_____ _____

Other Medical Problems / Allergies: _____

Are you the current resident of a Skilled Nursing Facility? Yes / No *(circle one)*

Do you currently wear a pacemaker? Yes / No *(circle one)*

Have you had X-Rays, MRI's, etc for this condition? Yes / No *(circle one)* Results?_____

_____

_____

What (if any) medications are you taking at this time?

| *Medication:* | *Dosage? How often?* | *Reasons* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have you had previous Physical Therapy for this condition? Yes / No *(circle one )*

If yes, where?_____

If yes, what helped your condition? _____

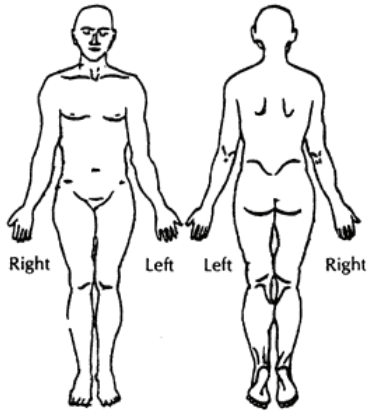
If so, what hindered your condition? _____

## Current Condition

How were you hurt/injured? _____

Since the onset of your condition, are your symptoms (circle one):
Getting Better / Getting Worse / Staying the same

Use the diagram to the right to indicate the location of your symptoms or pain.




Describe your symptoms (throbbing, burning, stabbing, aching, radiating, etc):

_____

_____

**On the scale below, please circle the number that indicates your current pain.**

| No Pain | Minor Pain | | | Moderate Pain | | | Severe Pain | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Pain free | Very mild | Discomforting | Tolerable | Distressing | Very distressing | Intense | Very intense | Utterly horrible | Excruciating Unbearable | Unimaginable Unspeakable |
| Normal | Nagging, annoying, but does not interfere with most daily living activities. | | | Interferes significantly with daily living activities. Requires lifestyle changes, though able to remain generally independent. | | | Disabling. Unable to perform daily living activities or engage in normal activities independently. | | | |

In the past week, highest your pain level? _____ In the past week, lowest your pain level ? _____

**Please check all activities that are painful or difficult to perform:**

**Self - Care**

- ☐ Urination
- ☐ Defecating
- ☐ Personal Hygiene
- ☐ Grooming hair
- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Brushing teeth

**Communications**

- ☐ Writing
- ☐ Typing
- ☐ Speaking

**Sensory Function**

- ☐ Hearing
- ☐ Seeing
- ☐ Tactile Feeling
- ☐ Numbness

**Physical Activity**

- ☐ Sit to stand
- ☐ Climbing stairs
- ☐ Reaching
- ☐ Sleeping

**How long can you:** (Mark "NL" if Not Limited)

- ☐ Sit _____ (min)
- ☐ Stand _____ (min)
- ☐ Walk _____ (min)

☐ Other aggravating factors or difficult activities: _____

What makes pain/symptoms worse? _____

What makes pain/symptoms better? _____

Is your pain/symptoms different in the morning or evening? Please describe. _____

_____

What do you hope to achieve through therapy? _____

Additional information_____

_____

**Patient signature:** _____ **Date:**_____

# The Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. For each activity please circle only one.

Today, do you or would you have any difficulty at all with:

| | Activities | Extreme Difficulty or Unable to Perform Activity | Quite a Bit of Difficulty | Moderate Difficulty | A Little Bit of Difficulty | No Difficulty |
|---|---|---|---|---|---|---|
| 1 | Any of your usual work, housework, or school activities. | 0 | 1 | 2 | 3 | 4 |
| 2 | Your usual hobbies, recreational or sporting activities. | 0 | 1 | 2 | 3 | 4 |
| 3 | Getting into or out of the bath. | 0 | 1 | 2 | 3 | 4 |
| 4 | Walking between rooms. | 0 | 1 | 2 | 3 | 4 |
| 5 | Putting on your shoes or socks. | 0 | 1 | 2 | 3 | 4 |
| 6 | Squatting | 0 | 1 | 2 | 3 | 4 |
| 7 | Lifting an object, like a bag of groceries from the floor. | 0 | 1 | 2 | 3 | 4 |
| 8 | Performing light activities around your home. | 0 | 1 | 2 | 3 | 4 |
| 9 | Performing heavy activities around your home. | 0 | 1 | 2 | 3 | 4 |
| 10 | Getting into or out of a car. | 0 | 1 | 2 | 3 | 4 |
| 11 | Walking 2 blocks. | 0 | 1 | 2 | 3 | 4 |
| 12 | Walking a mile. | 0 | 1 | 2 | 3 | 4 |
| 13 | Going up or down 10 stairs (about 1 flight of stairs). | 0 | 1 | 2 | 3 | 4 |
| 14 | Standing for 1 hour. | 0 | 1 | 2 | 3 | 4 |
| 15 | Sitting for 1 hour. | 0 | 1 | 2 | 3 | 4 |
| 16 | Running on even ground. | 0 | 1 | 2 | 3 | 4 |
| 17 | Running on uneven ground. | 0 | 1 | 2 | 3 | 4 |
| 18 | Making sharp turns while running fast. | 0 | 1 | 2 | 3 | 4 |
| 19 | Hopping | 0 | 1 | 2 | 3 | 4 |
| 20 | Rolling over in bed. | 0 | 1 | 2 | 3 | 4 |
| | **Column Totals:** | | | | | |

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

# Arrowhead Orthopaedics | FINANCIAL POLICY

**Welcome to Arrowhead Orthopaedics, and thank you for choosing us as your care provider. We are committed to providing you the finest care, and like you to understand that payment of your bill is necessary for maintaining quality care. For this reason, we have adopted the following statement as our financial policy, which we require that you read, agree to and sign prior to receiving any service.**

**PAYMENT RESPONSIBILITY:** Since you are the individual seeking care, you are responsible for payment of all charges associated with your visit. As a courtesy, and for your convenience, we will bill your insurance companies when you have provided us all the requested insurance information. **You are responsible for annual deductibles, co-payments, percentages, and uncovered services at the time the service is rendered.** If uncertain of your coverage, please contact your insurance. If the insurance payment is not received within 60 days of our office billing, you are immediately responsible for the full account balance. It is the policy of Arrowhead Orthopaedics that in the case of separation or divorce, the parent bringing in a child for treatment is responsible to pay for services.

If you choose not to bill your insurance for care provided, it is understood that you assume financial responsibility for all charges. Also, if you are seeking treatment under Workman's Compensation, please submit your employer authorization for treatment. Services would be provided on a self-pay basis until the authorization is received.

**PATIENT BILLING:** Patients who have outstanding balances are billed monthly. All balances are due 30 days from the billing date. When the account balance has not been paid within 30 days of the office billing and you have not contacted the office regarding the account, your account may be referred to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to our professional collection company. Once an account has been referred to collection, the office will provide additional services to the patient or the patient's family members only if the account is paid in full, or arrangements are made for the payment of the balances due. All costs incurred in the collection process shall be added to the original balances due.

**METHODS OF PAYMENT:** We accept cash, personal checks, Visa, MasterCard, American Express and Discover as payment for our services. Payments can be made in person, by phone or through our website at http://www.arrowheadortho.com. A $45.00 fee is charged for all returned checks.

**CREDIT CARD ON FILE:** At the time of check-in, you will be asked for a credit card number to keep on file. When your insurance processes your medical claim and notifies us of your share, an AO Representative will call you to confirm the amount due and get your verbal approval for the charge. A copy of the charge (receipt) will be mailed to you or if you prefer, by e-mail.

Credit Card Type (check one): ☐ Mastercard ☐ Visa ☐ Amex ☐ Discover
Last 4 digits of credit card number: _____
Cardholder Signature: _____ Date: _____

I, the undersigned, have read, clearly understand and agree to the provisions of this financial policy. I also authorize the release of any medical information necessary to process the claim and request, from my insurance carrier, payment of benefits to Arrowhead Orthopaedics for the services rendered.

____ At this time I prefer not to have Arrowhead Orthopaedics bill my insurance.

Name: _____ Signature: _____

Date: _____ Acct #: _____ [Office Use Only]

**[Please present your driver's license and insurance information to the receptionist.]**

# THERAPY NON-COVERAGE POLICY

ARROWHEAD ORTHOPAEDICS
*"A Tradition of Excellence"*

Welcome to Arrowhead Orthopaedics Physical and Occupational Therapy, and thank you for entrusting your medical care to our medical providers. All of us at Arrowhead Orthopaedics Physical and Occupational Therapy are committed to providing you with the best quality care in a pleasant and caring atmosphere.

As a courtesy and convenience to our patients, we verify insurance coverage in advance to determine eligibility. However, we do encourage our patients to be educated in their own insurance coverage as our calls to your insurance carrier do not guarantee payment. Based on your individual health plan, some services we provide may not be covered by your insurance company but is medically necessary for your treatment. Listed below are some procedures or modalities that may be denied by your insurance carrier:

| | | |
|---|---|---|
| Vasopneumatic devices | Modality: any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electrical energy. | Estimated Cost: $18.62 per unit |
| Electrical Stimulation | Modality: any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electrical energy. | Estimated Cost: $14.04 per unit |
| Therapeutic procedure(s), group (2 or more individuals) | Therapeutic Procedure: a manner of effecting change through the application of clinical skills and/or services that attempt to improve function. Direct patient contact. | Estimated Cost: $21.63 per unit |

We are notifying you of this possible non-coverage so you can make an informed decision about your care.

Please sign below indicating that you have read and clearly understood our non-coverage policy, and that you accept the terms presented herein.

Name: _____ Signature: _____

Date: _____ Notifier: _____