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

ARROWHEAD ORTHOPAEDICS
PHYSICAL THERAPY

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? _____

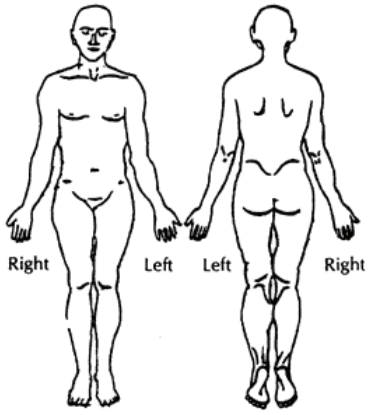
If so, what hindered your condition? _____

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:**_____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Name: _____ **Date: _____**

Instructions: Please circle *ONLY ONE NUMBER* in each section which most closely describes your problem.

SECTION 1 - PAIN INTENSITY
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor?
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
4. Pain prevents me lifting heavy weights but I can manage light medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

SECTION 4 - WALKING
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

SECTION 5 - SITTING
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

SECTION 6 - STANDING
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing becasue it increases the pain immediately.

SECTION 7 - SLEEPING
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my soclal life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

SECTION 9- TRAVELING
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while travleing which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under 1/2 hour.
5. Pain restricts all forms of travel.

SECTION 10 - CHANGING DEGREE OF PAIN
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

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: _____