ORTHOMEMPHIS

REHABILITATION SERVICES (PT/OT) - PATIENT INFORMATION SHEET

Name: _____ Middle Initial + Suffix: ____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Previous Last Name: _____ Age: _____ DOB: _____ **SSN:** _____

Address: _____ Sex: _____ **Language:** _____

Zip: _____ City: _____ State: _____ **Race:** _____ ☐ Declined

Pharmacy: _____ **Phone:** _____ **Ethnicity:** _____ ☐ Declined
(PRINT PHARMACY NAME) (PRINT PHARMACY PHONE)

Home Phone: _____ **W**ork Phone: _____ **C**ell Phone: _____

Email Address: _____ Contact Preference: ☐ Home ☐ Cell ☐ Work ☐ Email

Skilled Nursing Facility: ☐ **Yes** ☐ **No** Name: _____ Phone: _____

Employer/School: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Student

Employer/School Address: _____ Phone: _____

Patient Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Partner

How did you hear about us? _____ Family Doctor: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Guarantor/Guardian Last Name: _____ First: _____ Middle Initial + Suffix: _____

Guarantor Address: _____ Phone: _____ Work: _____

Cell Phone: _____ Zip: _____ City: _____ State: ____ SSN: _____

DOB: _____ Employer: _____ Employer Address: _____

REASON for this visit: ☐ **LEFT** ☐ **RIGHT** **BODY PART:** _____

Type of Injury: ☐ **WORK RELATED** ☐ Auto Injury Date: _____ State: _____

Where and how were you injured? _____

	PRIMARY	**SECONDARY**
Insurance Company:	**(1)**	**(2)**
Claims Address:		
City, State, Zip:		
Phone:		
ID/Policy #:		
Group/Plan #:		
Subscriber's Date of Birth:	☐ M ☐ F	☐ M ☐ F
Name of Subscriber:		

I have been shown a copy of MSK Group, P.C., Privacy Notice and have been provided with a Patient Consent Form for treatment. The financial policy of MSK has been provided to me and I agree to the terms as stated in that policy. I hereby assign to MSK all benefits payable under the terms of my insurance policy listed above. I realize that I am responsible for any balances not payable by my insurance company. I also understand that I will be responsible for any expenses incurred in the collection of outstanding balances that I may have, whether it be from a collection agency or an attorney. I hereby authorize the release and disclosure of my Protected Health Insurance (PHI) for treatment, payment, or health care operations.

Signature of Patient/Guardian: _____ Date: _____

(Must be 18 years old or older to sign)

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MEDICAL HISTORY

Name: _____ Date: _____ Chart: _____

Referring Physician: _____ Date of Next Visit: _____

Employer: _____ Current Job: _____

Are you currently working? ☐ Yes ☐ No Accident Related: ☐ Yes ☐ No Date of Injury: _____

Osteoporosis	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Lung Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Liver Problems	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No

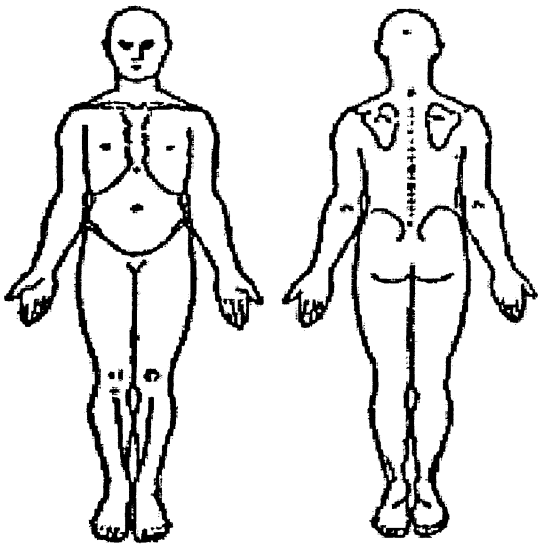
Surgical History: _____

_____

Medications: _____

_____

On the diagram below please mark where you are feeling pain or discomfort this episode.



Mark below on the scale from 0 to 10 the level of your pain or discomfort with 0 being None and 10 being Unbearable.

0 1 2 3 4 5 6 7 8 9 10

Signature: _____ Date: _____

I acknowledge the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I know and understand that **ortho**memphis, a division of MSK Group, PC is not responsible for loss or damage to personal items. I irrevocably assign all medical benefits directly to **ortho**memphis for treatment. I authorize release of any medical records necessary to process medical claims.

OrthoMemphis

A division of MSK Group, P.C.

ORTHOMEMPHIS

MSK GROUP, PC

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial, and privacy policies. If you have any questions, please inform a member of our front-desk staff.

Consent for Medical Treatment

I authorize the physicians of MSK Group, PC (MSK) and their health care team to render the evaluation and medical treatment needed. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary by my health care provider.

Consent for Electronic Prescribing

I authorize the physicians, and other appropriate licensed providers of MSK and their healthcare team to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications from any and all health care providers.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge I have been offered and/or received a copy of the Privacy Practices Notice of MSK. The Group and its representatives may contact me and leave a voicemail message if necessary unless I completed a *Restriction Form* which has been approved in writing by MSK.

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by MSK. I assign and authorize payments of medical insurance benefits to MSK directly, and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fees, court costs, and collection agency costs in the event of default of payment of my charges. It is my responsibility to contact my insurance company and/or employer to verify that MSK and its licensed medical providers are participants in my insurance plan prior to treatment at MSK. MSK does not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance products, and I am responsible for the full payment of services at the time rendered.

If my insurance plan requires a referral in order to be treated by an MSK provider, it is my responsibility to obtain the referral prior to being treated at MSK. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

MSK will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or with a plan MSK does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network," I am responsible for the balance.

Some insurance companies may determine that certain orthopaedic supplies that healthcare professionals prescribe for the patient's well being are not covered. I agree to pay for these supplies in the event my insurance company denies coverage.

MSK accepts cash, check, bank debit card, MasterCard, Visa, or Discover. Each instance of a returned check is subject to a $15 processing fee.

Signature of Patient/Guardian: _____ Date: _____

(Must be 18 years old or older to sign)

In the event we cannot contact you, please list family members or other persons, if any, who we may inform about your general medical condition and diagnosis.

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

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NOTICE OF FINANCIAL RELATIONSHIP / INTEREST

OrthoMemphis

A division of MSK Group, P.C.

This is to advise you that certain physicians of OrthoMemphis, a division of MSK Group, P.C. have a financial interest in the OrthoMemphis Physical Therapy Center, OrthoMemphis MRI Center and other area ambulatory/outpatient surgery centers.

With regard to physical therapy services, a physician of OrthoMemphis may refer _____ to the OrthoMemphis Physical Therapy Center. This center is owned by the physicians of OrthoMemphis.

T.C.A. §63-6-602© requires a physician who refers a patient for physical therapy to provide certain notices if the physician has a financial relationship with that physical therapy practice.

This document serves as an additional notice of the following:

* Your OrthoMemphis physician may have a financial interest in the physical therapy practice he is referring you to;
* You have a right to receive physical therapy services at any physical therapy practice of your choice;
* You have the option to use an alternative physical therapy practice;
* You will not be treated any differently by this practice or by your physician if you choose not to use the OrthoMemphis Physical Therapy Center.

Patient / Parent / Legal Representative **Initial:**_____ **Date:**_____