HIPAA WRITTEN ACKNOWLEDGEMENT OF RECEIPT
NONDISCRIMINATION POLICY

I acknowledge that I have received from Orthopedic & Spine Therapy a written notice of Orthopedic & Spine Therapy's privacy practices from protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the notice also contains:

- A description of the types of uses and disclosures that Orthopedic & Spine Therapy is permitted to make for treatment, payment, or health care operations with and without my written authorization.
- A description of each of the other purposes for which Orthopedic & Spine Therapy is permitted or required to use or disclose protected health information without my written authorization.
- A description of uses or disclosures that may be limited or prohibited by law.
- The description contains sufficient detail to make me aware of the use or disclosures that are permitted or required by the federal privacy rule and other applicable law.
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right.
- A statement describing the Orthopedic & Spine Therapy duties under the federal privacy law.
- A statement describing how I may express concern to the Orthopedic & Spine Therapy and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated.
- I have received information explaining how to contact Orthopedic & Spine Therapy for further information and the effective date which the notice is first in effect.
- I understand and agree that testimonials or comments that I share may be used at Orthopedic & Spine Therapy's discretion for promotional material, digital advertising, and/or their website.

I, _____, acknowledge that I have received the written notice of Privacy Practices from Orthopedic & Spine Therapy.

_____ _____

Patient Signature Date

As a recipient of Federal financial assistance, Orthopedic & Spine Therapy does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities.whether carried out by OST directly or through a contractor or any other enchy with which OST arranges to carry out its programs and activities.

This statement is in accordance with the provision of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Regulations of the US Department of Health and Human Services issued pursuant to these statutes of Title 45 Code of Federal Regulations Part 80, 84, and 91.

In case or questions, please contact: Orthopedic & Spine Therapy, Amy Barnett. 920.257.2005

Financial/Consent to Treat Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is our Financial/Consent to Treat Policy statement, which we require you to read and sign before treatment. If at any time you have questions regarding any treatment, fees, or services please discuss them with us.

REGARDING INSURANCE: As a courtesy to you, we will bill your insurance carrier. Please be aware some and perhaps all services may be "noncovered" and are not considered reasonable and necessary under some medical insurance policies. Also, we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Co-pays are due at the time of your appointment.

MEDICARE: We do accept assignments for Medicare. There are certain guidelines that we, as an independent physical therapy practice, are required to follow. You agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy for any services furnished. In addition, you agree to authorize payment of Medicare benefits to Orthopedic & Spine Therapy for any services furnished.

WORKERS' COMPENSATION: In the case of a work-related claim, we will bill the appropriate workers' compensation carrier. If the claim is unsettled or unpaid within 60 days, you will receive a statement from our office. If the claim is denied, you will receive notice from the workers' compensation carrier. Upon notification, we will bill you or your personal health insurance carrier. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim. Additionally, I agree to authorize OST to forward my medical records with all claims to work comp carriers and/or employers to assist in claims processing.

INJURIES/ACCIDENTS INVOLVING LEGAL LITIGATIONS: We will not bill third-party insurance if your injury or accident involves legal litigation; however, we will bill you or your health insurance. We will require you to make payments on the charges even if the third party will cover them. Documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim.

CANCELLATIONS/NO-SHOWS: We require a 24-hour notice in the event of a cancellation. There is a $50 charge per 40-minute appointment for cancellation without proper notice or failure to show for your scheduled appointment. This charge will not be covered by insurance and the patient/responsible party will be financially responsible for the balance. Additionally, if you fail to show or cancel more than two times during treatment, OST reserves the right to discharge you from care.

NON-SUFFICIENT FUNDS (NSF) CHECKS: There is a $50 charge for returned checks with insufficient funds.

COLLECTION AGENCY PLACEMENT POLICY: You are financially responsible for the timely payment of your outstanding bill per our payment policies. You will be responsible for any and all collection agency fees up to 30% of the amount placed with the collection agency. In the event we seek legal action for the collection of your account, you will also be responsible for actual fees associated with the court costs, garnishments, and/or attorney fees.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS: You hereby authorize Orthopedic & Spine Therapy to provide treatment, release information pertaining to your treatment for insurance purposes, and/or to receive direct insurance payments otherwise payable to you for services rendered.

CONSENT TO TREAT: There are potential risks and benefits of physical therapy treatment. Potential benefits include an improvement in your symptoms and/or an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You will have a greater knowledge of managing your condition and the resources available to you. Potential risks may be due to the many movements and positions that are performed. It is not uncommon to experience temporary discomfort after treatment. Any concerns should be addressed with your therapist. **Supplies: During the course of treatment, there may be supplies that will be beneficial to your treatment. These are sold on a cash basis and not billed to your insurance. Pricing will vary by item.** Therapy will be most effective when you are compliant with your treatment plan as outlined by your physical therapist.
If you have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the Financial/Consent to Treat Policy. I understand and agree with this policy.

_____ _____

(Patient or Responsible Party Signature) (Date)

ORTHOPEDIC SPINE THERAPY

Patient Intake Form

Name _____ **Date Of Evaluation** _____

DOB _____/_____/_____ **Age** _____

It is important for us to know how our patients hear about us. Who can we thank for your referral to OST?
☐ MD/NP ☐ Family ☐ Friend *(optional, provide name)* _____ ☐ Newsletter ☐ Employer ☐ Social Media
☐ Linkedin ☐ Advertisement ☐ Magazine ☐Community Talk ☐ Website ☐Other _____

Email _____ **Next MD Visit** ___/___/___ **Referring MD**_____

Family MD _____**Occupation**_____ **Job Description**_____

Work Status: ☐ Full-time ☐ Full-time, with restrictions ☐ Part-time ☐ Part-time, with restrictions
☐ Not Working/Retired ☐ Maternity Leave ☐ Medical Leave ☐ Other _____

Living Situation: ☐ House ☐ Apartment **Do you feel safe at home?** ☐ Yes ☐ No ☐ _____

Leisure Activities _____
How do you learn best? ☐ Listening ☐ Seeing ☐ Doing ☐ Comment _____

What specific issues do you want addressed? _____

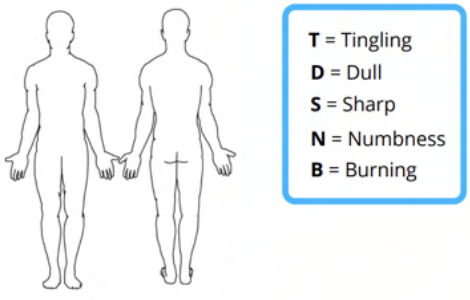
When did your problem develop? Exact Date ___/____/_____

How did your problem begin? _____

Since your problem began, is it: ☐ Improving ☐ Staying the same ☐ Worsening

Are you right hand or left hand dominant? ☐ Right ☐ Left **Is your pain:** ☐ Consistent ☐ Intermittent

Please note on the diagram where you're experiencing pain, using the appropriate letters below:



Rate your pain: 1 - 10 (10 being extreme): At present: _____ **At best:** _____ **At worst:** _____

PERSONAL GOALS

List and score at least 3 activities that you are unable to perform or have the most difficulty performing because of your chief complaint.

On a 0-10 scale, the HIGHER the number, the EASIER. The LOWER the number, the more DIFFICULTY you have. 0 = unable to perform activity ; 10 = fully able to perform activity

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

Activity: _____ **Score:** _____

Are there any activities or positions that significantly *worsen* your symptoms?

☐ Sitting ☐ Walking ☐ Lying Down ☐ Ice ☐ Intercourse ☐ Coughing/sneezing ☐ Standing
☐ Lifting ☐ Bending ☐ Heat ☐ Other _____ ☐ Bowel/bladder movements

Are there any activities or positions that significantly *improve* your symptoms?

☐ Sitting ☐ Walking ☐ Lying Down ☐ Ice ☐ Intercourse ☐ Coughing/sneezing ☐ Standing
☐ Lifting ☐ Bending ☐ Heat ☐ Other _____ ☐ Bowel/bladder movements

Are you currently receiving the following treatment with another provider?

☐ Physical Therapy ☐ Home healthcare ☐ Nursing facility services ☐ Chiropractic ☐ Massage

Have you had prior treatment(s) for this condition?

☐ Physical Therapy ☐ Injections ☐ Surgery ☐ Chiropractic ☐ Massage ☐ Acupuncture
☐ Other _____

Have you had any recent diagnostic tests?

☐ Bone scan ☐ EMG ☐ Urodynamics ☐ X-Ray ☐ CT scan ☐ Urinalysis ☐ MRI
☐ Other _____

Please list all allergies:

☐ Seasonal ☐ Medications ☐ Latex ☐ Food ☐ Nickel ☐ Environmental ☐ Other _____

Please list all medications you are currently taking (or attach list) :

_____

At the present time, would you say that your health is: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Past Surgical History *(please include dates to the best of your ability):*

☐ Joint replacement _____
☐ Spinal fusion _____
☐ Laminectomy/discectomy_____
☐ Shoulder surgery_____
☐ Elbow/hand/wrist surgery _____
☐ Hip surgery _____
☐ Knee surgery _____
☐ Ankle/foot surgery _____
☐ Hernia repair _____

☐ Cesarean section_____
☐ Hysterectomy_____
☐ Appendix removal _____
☐ Gallbladder removal_____
☐ Abdominal surgery_____
☐ Laparoscopy_____
☐ Bladder surgery_____
☐ Prostate surgery_____
☐ Hemorrhoid surgery_____
☐ Implanted devices_____

☐ Gastric bypass_____
☐ Ileostomy_____
☐ Colostomy_____
☐ Vasectomy_____
☐ Coccyx removal_____
☐ Abortion_____
☐ D&C_____
☐ Prostate surgery_____
☐ Pudendal nerve surgery_____
☐ Other_____

Please check *all conditions* below that apply to you:

HEART & CIRCULATION	BONES & JOINTS	LUNGS & BREATHING
☐ High blood pressure ☐ Pain/tightness in the chest ☐ Cold hands/feet ☐ Numbness in hands/feet ☐ Anemia ☐ Blood clots ☐ Easy bleeding ☐ Heart attack ☐ Pacemaker ☐ Bypass surgery ☐ Heart murmur ☐ Other _____	☐ Chronic fatigue syndrome ☐ Arthritis ☐ Rheumatoid arthritis ☐ Fibromyalgia ☐ Tailbone pain ☐ Osteoporosis ☐ Easy bleeding ☐ Stress fracture ☐ Joint replacement ☐ Bypass surgery ☐ Scoliosis ☐ Other _____	☐ Shortness of breath ☐ Currently Smoking ☐ History of smoking ☐ Asthma ☐ Emphysema/bronchitis ☐ COPD ☐ Other_____

SKIN CONDITIONS	OTHER MEDICAL CONDITIONS	OTHER MEDICAL CONDITIONS
☐ Eczema ☐ Contact Dermatitis ☐ Lichens Sclerosis ☐ Psoriasis ☐ Other_____	☐ Diabetes ☐ Cancer ☐ Melanoma ☐ Lupus ☐ Stroke ☐ Hearing Loss ☐ Ringing in ears ☐ Vision/eye problems ☐ Dizziness ☐ Depression ☐ Anxiety ☐ Prolapse ☐ Incontinence ☐ Headaches ☐ Hyperthyroid ☐ Hypothyroid	☐ Head injury ☐ Epilepsy/seizures ☐ Multiple sclerosis ☐ Irritable bowel syndrome ☐ Ulcers ☐ Hernia ☐ Kidney problems ☐ Hepatitis ☐ Alcohol/drug addiction ☐ Vomiting ☐ Unexplained weight change ☐ Sweating ☐ Chills ☐ Sexually transmitted disease ☐ Falls in the last 6 months ☐ Metal implants ☐ Breast implants ☐ HIV/AIDS ☐ Other _____

Please explain any checked items in the chart and add others not listed.

_____

What do you hope to accomplish in physical therapy?

_____

Patient Signature _____ Date ___/_____/_____ PT Initials _____