*1068 Main Street, Suite A, Sanford, Maine 04073* *(207) 324-6789 fax: (207) 324-9394*
*360 U.S. Route One, Suite 100, Scarborough, Maine 04074* *(207) 883-6789 fax: (207) 885-9394*

## NEW PATIENT INFORMATION

PATIENT NAME: ______________________ DOB: __________ AGE: _____ DATE: ________/2009

MAILING ADDRESS: ____________________________________________
STREET CITY STATE ZIP

HOME ADDRESS (IF DIFFERENT FROM ABOVE): ____________________________________________

SOCIAL SECURITY: ______________ HOME PHONE: ______________ CELL: ______________

EMPLOYER: ______________________ OCCUPATION: ______________

ADDRESS: ____________________________________________
STREET CITY STATE ZIP

BUSINESS PHONE: ______________________ EXT: ________

SPOUSE (PARENT): ______________ BIRTH DATE: ________ SOCIAL SECURITY: ______________

EMPLOYER: ______________________ OCCUPATION: ______________

ADDRESS: ____________________________________________
STREET CITY STATE ZIP

BUSINESS PHONE: ______________________ EXT: ________

CLOSEST RELATIVE NOT LIVING WITH YOU: ______________________ PHONE: ______________

**What is the date of your next scheduled visit with your referring physician?** ______________________ **Time?** ________

May we add you to our e-mail mailing list to receive newsletters or other pertinent material that you may find helpful? If so, please provide your

e-mail address: ______________________

## INSURANCE INFORMATION

**WORK RELATED: YES/NO** **ACCIDENT RELATED: AUTO/OTHER** **STATE OF ACCIDENT** ______________

IF YES, **DATE OF INCIDENT**: ______________________ CLAIM NUMBER: ______________

ATTORNEY: ______________________ PHONE: ______________ EXT: ________

ADDRESS: ____________________________________________
STREET CITY STATE ZIP

**PRIMARY** INSURANCE: ______________________ GROUP NO. ________ ID NO. ________

ADDRESS: ____________________________________________
STREET CITY STATE ZIP

PHONE: ______________ EXT: ________ CONTACT PERSON: ______________

NAME OF INSURED: ______________________ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

**SECONDARY** INSURANCE: ______________________ GROUP NO. ________ ID NO. ________

ADDRESS: ____________________________________________
STREET CITY STATE ZIP

PHONE: ______________ EXT: ________ CONTACT PERSON: ______________

NAME OF INSURED: ______________________ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

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# PERSONAL & FAMILY MEDICAL HISTORY

| **Name:** | **DOB:** | **Today's Date:** |
|---|---|---|
| | | |

**Medical Testing**

| Please list or attach a list of any **prescription or over-the-counter medications** that you are taking currently. | | | **None** |
|---|---|---|---|
| Medication | Dose | Frequency | Reason |
| | | | |
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| Please list any **radiographs (X-Ray), sonograms (ultrasound), bone scans, computed tomography (CT) scans, or magnetic resonance imaging (MRI)** you have had recently. | | **None** |
|---|---|---|
| When | Where | Test Results |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list any **laboratory work (urinalysis, blood tests or other)** that you have had recently. | | **None** |
|---|---|---|
| When | Where | Test Results |
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list any **operations** that you have ever had. | | **None** |
|---|---|---|
| When | Where | Test Results |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Name: | DOB: | Today's Date: |
|---|---|---|
| | | |

| General Health | Circle One | |
|---|---|---|
| Have you had any illnesses within the last 3 weeks (fever, cold, influenza, bladder or kidney infection)? | Yes | No |
| Have you noticed any lumps or thickening of skin or muscle anywhere on your body? | Yes | No |
| Do you have any warts, moles or sores that have changed in size, shape or color or have not healed? | Yes | No |
| Have you had any unexplained weight gain or loss in the last month? | Yes | No |
| Have you had any fever, chills or night sweats? | Yes | No |
| Have you had any recent alteration in bowel or bladder habits, trouble initiating urination, change in urinary frequency or loss of control of your bowels or bladder? | Yes | No |
| Have you had any recent headaches, nausea, vomiting, or ringing in your ears? | Yes | No |
| Have you had any recent light headedness, dizziness, sensation that you may faint or actual loss of consciousness? | Yes | No |
| Have you had any recent weakness or sense of fatigue? | Yes | No |
| Is there any chance you may be pregnant? | Yes | No |
| Do you or have you ever smoked or chewed tobacco? | Yes | No |
| If yes, how many packs/day? | | |
| How many months or years? | | |
| When did you quit? | | |
| How much alcohol do you drink in the course of a week? | | |
| How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)? | | |
| Are you on any special diet prescribed by a physician? | Yes | No |
| Do you have a pacemaker, transplanted organ, or metal implants (including joint replacement or IUD)? | Yes | No |

| Work Environment | | |
|---|---|---|
| **Occupation:** | | |
| **Does your job involve the following:** | Circle One | |
| Prolonged sitting (e.g., desk, computer, driving) | Yes | No |
| Prolonged standing (e.g., equipment operator, sales clerk) | Yes | No |
| Prolonged walking (e.g., mill worker, delivery service) | Yes | No |
| Use of large or small equipment (e.g., fork lift, drill press, typewriter, telephone, cash register) | Yes | No |
| Lifting, bending, twisting, climbing, turning | Yes | No |
| Exposure to chemicals, pesticides, toxins | Yes | No |
| Other, please describe: | | |
| **Do you use any special supports:** | Circle One | |
| Back cushion, neck cushion | Yes | No |
| Back brace, corset | Yes | No |
| Other kind of brace or support for any body part | Yes | No |
| Other, please describe: | | |

| Other | | |
|---|---|---|
| **History of falls:** | Circle One | |
| I have had falls | Yes | No |
| I have just started to lose my balance/fall | Yes | No |
| I fall occasionally | Yes | No |

| Name: | DOB: | Today's Date: |
|---|---|---|
| | | |

## Past Medical History

| Have you or any one in your immediate family (parents, brother, sister) ever been diagnosed with or treated for any of the following: | | | **NOTES**: |
|---|---|---|---|
| **CHECK ONE:** | Self | Family | |
| Heart disease/arrhythmia | | | |
| Angina or chest pain | | | |
| Hypertension or high blood pressure | | | |
| Hypoglycemia | | | |
| Shortness of breath | | | |
| Asthma | | | |
| Allergies, hay fever | | | |
| Chronic bronchitis | | | |
| Emphysema | | | |
| Pneumonia | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| Cancer | | | |
| Thyroid problems | | | |
| Anemia | | | |
| Hemophilia/slow healing | | | |
| AIDS/HIV-positive | | | |
| Kidney disease/stones | | | |
| Cirrhosis/liver disease | | | |
| Hepatitis/jaundice | | | |
| Urinary tract infection | | | |
| Rheumatic fever/scarlet fever | | | |
| Ulcers/stomach problems | | | |
| Arthritis/gout | | | |
| Osteoporosis/Low bone density | | | |
| Rheumatoid Arthritis | | | |
| Fibromyalgia/myofascial pain syndrome | | | |
| Migraine headaches | | | |
| Stroke | | | |
| Seizures/Epilepsy | | | |
| Multiple sclerosis | | | |
| Polio | | | |
| Guillain-Barre syndrome | | | |
| Other (please describe) | | | |

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# PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Payment Policy which we require you to read and sign prior to any treatment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. In the event that any payments due OPTA under this assignment are received by me, I hereby agree to endorse such payments and forward them directly to OPTA. (Checks should be signed on the back and followed by "Pay to the order of OPTA"). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. I understand that after my account is 90 days past due I will be charged 1.5% interest per month (18% annual percentage rate) for all outstanding balances. Additionally, there will be a minimum monthly service charge of $2.00. In the event of default I promise to pay interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

My signature below acknowledges that I have read and understand the billing policy.

Thank you.

____________________________________
Signature

____________________________________
Date

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# WORKER'S COMPENSATION
# PAYMENT POLICY AND ACKNOWLEDGEMENT

At the time your appointment was made, it was indicated that your employer's insurance carrier is assuming responsibility for your medical bills. You must have the acknowledgement completed by your employer and/or worker's compensation carrier.

**UNTIL WE RECEIVE THIS AUTHORIZATION, YOU WILL BE PERSONALLY RESPONSIBLE FOR THE CHARGES YOU INCUR.**

**YOU ARE, OF COURSE, ULTIMATELY RESPONSIBLE FOR THE ENTIRE BILL IF YOUR WORKER'S COMPENSATION CARRIER DENIES YOUR CLAIM.**

Your signature below acknowledges your understanding of our payment policy.

______________________________ ______________________________
SIGNATURE DATE

______________________________ ______________________________
NAME SOCIAL SECURITY NUMBER DATE OF BIRTH

______________________________ ______________________________
TELEPHONE NUMBER

______________________________
ADDRESS

## EMPLOYER'S WORKER'S COMPENSATION COVERAGE ACKNOWLEDGEMENT

______________________________ ______________________________
INSURANCE COMPANY EMPLOYER'S SIGNATURE

______________________________ ______________________________
NAME TITLE

______________________________
ADDRESS

______________________________
COMPANY

______________________________ ______________________________
TELEPHONE NUMBER

______________________________ ______________________________
CONTACT PERSON ADDRESS

______________________________ ______________________________
CLAIM NUMBER DATE OF ACCIDENT TELEPHONE

*C:\OPTA\FORMS\WCOMP.WPD*

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# NOTICE OF PRIVACY PRACTICES

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.

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**OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. You may request a copy of our Notice at any time.

---

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. The law also requires us to give you this Notice describing our legal duties, privacy practices, and your rights regarding your medical information. We must follow the terms of the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We have the right to change our privacy practices and the terms of this Notice at any time, provided that law permits the changes. We have the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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**USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

We may use medical information about you to provide you with **medical treatment** or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

We may use and disclose your medical information for **payment purposes**.

We may use and disclose your medical information for our **health care operations**. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**In addition** to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

**Notification** – We may use your medical information to notify or help notify a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medical supplies, x-rays or medical information for you.

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**Appointments –** We may use or disclose your health information to provide you with appointment information. For example, we may leave you a voice message.

**Disaster Relief** – We may share medical information with a public or private organization or person who can legally assist in disaster relief effort.

**Abuse, Neglect or Domestic Violence** – We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others.

**Court Orders and Judicial and Administrative Proceedings –** We may disclose medical information in response to a court of administrative order, subpoena, discover request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

**Workers Compensation** – We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

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**YOUR INDIVIDUAL RIGHTS**

**Access** - You have a right to look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this Notice. You may also request access by sending a letter to the contact person listed at the end of this Notice.

If you request copies, we will charge you $10 for the first page, and .35 cents for each page thereafter to cover the cost of personnel time, paper and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

**Disclosure Accounting -** You have a right to receive a list of all of the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

**Restrictions –** You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these conditions, but if we do, we will abide by our agreement (except in the case of an emergency).

**Communication** – You have the right to request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this Notice.

**Change of Medical Information** - You have the right to request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

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**QUESTIONS AND COMPLAINTS**
If you have any questions about this Notice, please contact:

Kathleen Tranchemontagne
Orthopaedic Physical Therapy Associates, Inc.
1068 Main Street, Suite A
Sanford, ME 04073
(207) 324-6789

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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## ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I have received the **Notice of Privacy Practices,** and I have been provided an opportunity to review it.

Signature________________________________________________

Date____________________________

## AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

The authorization to release this information is primarily for the purpose of communicating with your health care team in order to provide quality physical therapy treatments and administering your insurance program. It will not be furnished in an identifiable form to any party other than those named in this Authorization without your written consent unless expressly permitted or required by law.

Orthopaedic Physical Therapy Associates is hereby authorized to release or obtain my health care information to/from my referring health care provider, my primary care physician and members of their health care delivery staff. In order to bill and collect payment for services or to respond to inquires about services of payments, Orthopaedic Physical Therapy Associates is also authorized to release my medical information to representatives and contract service providers of my insurance company. Orthopaedic Physical Therapy Associates may also release my medical information to government agencies as stated in the Notice of Privacy Practices. This Authorization allows those named to view, discuss and obtain a copy of all records pertaining to the history, examination, treatment, prescriptions and medical expenses of the patient named herein. Health care information may also be given to the persons I have identified as my "closest relative" in order that they may be informed of my health condition in the event of an emergency. My health care information may also be given to my family or household members if it is necessary to do so in order for me to receive proper care.

I understand that I may revoke this authorization at any time by giving written notice to Orthopaedic Physical Therapy Associates. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

I have had the opportunity to read and think about the content of this authorization form, and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this Authorization with the people and/or organizations named in this form. My consent will stay in effect for 30 months from the date I sign this unless I revoke it.

Signature: ________________________________________ Date_____/_____/20_____
Month Day Year

If this authorization form is signed by a personal representative for the individual patient, complete the following:

Personal Representative's Name: ______________________ Signature: __________________________

Relationship to Individual Patient: __________________________

**YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT**