PATIENT INSTRUCTIONS: REGISTRATION FORMS

Physical Therapy, Hand Therapy, Chiropractic, & Fitness

Step 1: Before you come in, please:

Directions, meet your provider, learn how we work?
Go to: **ossburbank.com**

Save the Prescription for Therapy
- A prescription was given to you by your medical provider when s/he referred you to therapy. OSS Therapy will need to see this prescription at your 1st appointment.

Decide how you want to handle the fees:
- **Option 1. Use your insurance.**
  - OSS will check your benefits and get authorization BEFORE your visit.
  - Even if your health insurance is in network, you may be required to handle a deposit of up to $150 and/or copay.
- **Option 2. Be self-pay** (and use no insurance). To find out the price for service, go to ossburbank.com or ask OSS.

Fill out registration forms
- Fill out all forms in this packet.
- Read consents (e.g., no pets allowed)
- You can email completed forms to our office.

Need to cancel? To avoid the $60 cancellation fee, please notify us of the cancellation 24 hours (1 business day) before your appointment.

OSS THERAPY OFFICES

Burbank (Main Office)
Pacific Ave + Hollywood Way
3413 W. Pacific Ave, #200
Burbank, CA 91505
T: (818) 579-2370
F: (818) 579-2371
info@ossphysicaltherapy.com

Burbank (Artistic Advantage)
W Magnolia Ave
2211 Magnolia Blvd #295
Burbank, CA 91506
T: (818) 955-8303
F: (818) 579-2371
info@ossphysicaltherapy.com

Glendale
1300 S. Central Ave
Glendale, CA 91204
T: (818) 579-2395
F: (818) 579-2396
infoglendale@ossphysicaltherapy.com

Step 2: When you arrive, be ready with:

Arrival Time For All Appointments

Forms done? 10 minutes before
Not done? 20 minutes

- The Prescription for Therapy.
- Completed registration forms. If you emailed, let us know
- A list of current medications
- Wear loose fitting gym attire
- Photo ID, health insurance card, and credit card

MasterCard VISA DISCOVER AMERICAN EXPRESS

OSS
ossburbank.com

Emergency Contact Name:

Emergency Contact Relation:

Emergency Contact Ph:

PATIENT INFORMATION

First Name | Last Name | MI

Mailing Address

City | State | Zip Code

Cell Phone | Home Phone | Work Phone

DOB | Age | Sex ❍ Female ❍ Male | SSN#

Marital Status ❍ Married ❍ Single ❍ Divorced ❍ Widow ❍ Domestic Partner

Email Address

Employer Name | Occupation

Is this injury work-related? ❍ Yes ❍ No | Is this injury related to an auto accident? ❍ Yes ❍ No | Do you have Medical Insurance? ❍ Yes ❍ No

Do you have Medicare? ❍ Yes ❍ No | Is this injury related to a Workers' Comp claim? ❍ Yes ❍ No

Did you receive one or more of these services **at your home** in the last year? If yes, circle all that apply

Physical Therapy ☐ Hand Therapy ☐ Injection ☐ Blood pressure check ☐ Home Care Company Name:

Sugar check ☐ Temperature ☐ Hospice ☐ Bandage or wound check ☐ Home Care Company Ph number:

Responsible for payment (if other than patient; i.e., Parent, Spouse, Guardian): Name of Responsible Party

Mailing Address of Responsible Party

City | State | Zip Code

Cell Phone | Home or Work Phone

Name of Medical Insurance Company (PRIMARY)

Name of Medical Insurance Company (SECONDARY)

Policy Holder Name | Policy Holder DOB

Referring Physician

MEDICAL QUESTIONNAIRE

Chiropractic

KINDLY USE BLACK INK

GENERAL

Patient Name *Last Name* *First Name* *M.I.* | Today's Date (MM/DD/YY)

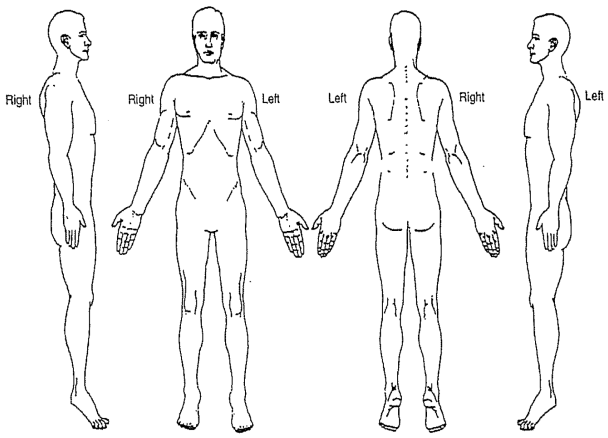
Gender ☐ F ☐ | Height | Weight

Which OSS provider referred patient for chiropractic care?

PAIN: What is the current level of your pain?

Mark the drawing below **with an X** to show where you have the most severe pain.

Shade in the areas where you have less severe pain.



On a scale of 0 - 10 (0=no pain, 10=worst pain possible), what is your level of pain? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How often do you have pain?

Co☐ntly Fre☐ntly Occa☐hallly Inter☐ently

Have you seen a chiropractor before? ◯No ◯Yes

If yes, what was the the date(s), duration, and location / name of clinic? _____

How did your pain start?

☐Work Injury ☐Illness ☐No Obvious Cause ☐njury, Not at Work ☐Motor Vehicle or Motorcyle Accident Other: _____

How long have you had this pain? _____

How often do you exeperience your pain symptoms? Constantly (76%-100%)☐ Frequently (51-75%)☐ Occasionally (26-50%)☐ Intermittently (0-25%)☐

How would you describe how your pain feels? _____ Sharp☐ Dull ache☐ Numb☐ Shooting☐ Burning☐ Tingling☐

Pain is at it's worst? AM☐ PM☐ As the day wears on☐ Steady on/off☐

What makes pain better? General Activity☐ Ice☐ Heat☐ Rest☐ Other:_____

What makes pain worse? General Activity☐ Bending☐ Lifting☐ Walking☐ Sports☐ Moving wrong☐ Getting up from a chair☐ Heating Pad☐ OTC Meds☐

Massage☐ Chiropractic☐ Other:_____

Has your sleep been affected by the complaint you presented with today?

What is your sleeping position?

Job physical demands_____

Recreational activities:_____

Have you had similar symptoms in the past? Yes☐ When?____

If you have received treatment in the past for the same or similiar symptoms, who did you see?

MEDICAL QUESTIONNAIRE

Chiropractic

KINDLY USE BLACK INK

GENERAL

Patient Name *Last Name* *First Name* *M.I.*

Today's Date (MM/DD/YY)

HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

			Date(s) Tried	Outcome / Reason(s) Stopped?
Services				
Physical Therapy	No	Yes		
TENS Unit	No	Yes		
Aqua Therapy	No	Yes		
Acupuncture	No	Yes		
Biofeedback	No	Yes		
Spinal Cord Stimulation (SCS)	No	Yes		
Relaxation, imagery, mindfulness	No	Yes		
Injections				
Epidural Injection	No	Yes		
Transforaminal (Nerve Block) Injection	No	Yes		
Sacroiliac (SI) Joint Injection	No	Yes		
Facet Injection	No	Yes		
Trigger Point Injection	No	Yes		
Rhizotomy Injection	No	Yes		
Other	No	Yes		
Regenerative Medicine				
Platelet Rich Plasma (PRP)	No	Yes		
Stem Cell	No	Yes		
Prolotherapy	No	Yes		
Cartilage Regeneration	No	Yes		
Nonsteroidal Medications				
Motrin (Ibuprofen)	No	Yes		
Aleve	No	Yes		
Naproxen	No	Yes		
Mobic (Meloxicam)	No	Yes		
Lodine (Etodolac)	No	Yes		
Other				
Aspirin	No	Yes		
Tylenol	No	Yes		
Other	No	Yes		
Muscle Relaxants				
Baclofen	No	Yes		
Robaxin	No	Yes		
Zanaflex	No	Yes		
Skelaxin	No	Yes		
Flexeril	No	Yes		

MEDICAL QUESTIONNAIRE

Chiropractic

KINDLY USE BLACK INK

GENERAL

Patient Name *Last Name* *First Name* *M.I.* | Today's Date (MM/DD/YY)

HISTORY OF TREATMENT: How have you tried to manage the pain?

Have you used any of these treatment(s) to ease your pain? Please check as it applies, provide the date(s), and describe outcome.

			Date(s) Tried	Outcome / Reason(s) Stopped?
Narcotics (Opiods)				
Codeine	No	Yes		
Percocet	No	Yes		
Oxycodone	No	Yes		
Hydrocodone (Norco)	No	Yes		
Opana (Oxymorphone)	No	Yes		
Morphine	No	Yes		
Oxycontin	No	Yes		
Avinza	No	Yes		
Hysingla	No	Yes		
Duragesic (Fentanyl)	No	Yes		
Suboxone	No	Yes		
Neuromodulators				
Neurontin (Gabapentin)	No	Yes		
Topamax	No	Yes		
Lyrica	No	Yes		
Cymbalta	No	Yes		
Gabitril	No	Yes		

What allergies do you have? _____

SOCIAL HISTORY: What social factors should we consider in your care?

Have you ever used any of the following drugs? Check as it applies.

Marijuana Heroin Suboxone Sedative / Downers Inhalants Amphetamines Cocaine Bath Salts

Please check your response. Scale: 1 = Never, 2 = Seldom, 3 = Sometimes, 4 = Often, 5 = Very Often

How often do you have mood swings?	1 2 3 4 5
How often do you smoke a cigarette within an hour of waking up?	1 2 3 4 5
How often have you taken medication other than the way it was prescribed?	1 2 3 4 5
How often have you used illegal drugs in the past five years?	1 2 3 4 5
How often in your lifeitme have you had legal problems or been arrested?	1 2 3 4 5

Comments: _____

Have you ever thought you should cut down on your drinking or drug use?	No Yes
Have people ever annoyed you by criticising your drinking or drug use?	No Yes
Have you ever had a drink or used drug in the morning to steady your nerves or get rid of a hangover?	No Yes
Are you currently seeing a mental health provider or counselor?	No Yes

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (Print): _____

Patient Signature: _____ Date: _____

Health Indicators Screening

Our physical and hand therapists are required to screen you for various health indicators (as of 2015). The categories include tobacco and alcohol use, body mass index, medications, and fall risk. It is your choice to refrain from answering questions, although OSS Physical & Hand Therapy feel that it is in your best interest to do so.

First Name _____ Last Name _____ Middle Initial _____

Body Mass Index

Weight_____ lbs. Height _____feet _____inches

Tobacco

Are you a smoker or tobacco user? ☐ Yes ☐ No

Alcohol Consumption in Past Year

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If yes, how often in the past year?

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week

If yes, how many drinks did you have a on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 to 6 ☐ 7 to 9 ☐ 10

If yes, how often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

If you are 65 years and older, please answer

Have you fallen 2 or more times in the past 12 months? ☐ Yes ☐ No

Have you had a fall in the past 12 months that resulted in an injury? ☐ Yes ☐ No

Do you have an advance care plan or surrogate decision maker? ☐ Yes ☐ No

MEDICATION RECORD					
Medication / Vitamin / Supplement	**Dose / Strength**		**Form of Medicine** *(Pill, shot, drops, etc)*	**Time of day**	**Is this medicine new within the last 6 weeks**

I certify that this information is complete and true. I acknowledge that nondisclosure of medical information could directly impact my health and services I receive. I further accept full responsibility in updating my therapist should any changes be made to my medical regimen.

It's a joint effort in making sure your medication list is current. In the event that your medication changes, please inform us as this information needs to be recorded each visit.

X

Signature Date

3413 W. Pacific Avene• Burbank, California 91505 • Ph 818.579.2370 • Fax 818.579.2371• www.ossburbank.com

CLINIC POLICIES

Below are OSS Physical & Hand Therapy office policies:

- Claims will be submitted to your insurance carrier however, all charges incurred will be the responsibility of the patient. Verification of benefits and authorization is not a guarantee of payment by the insurance company.
- Co-payments, co-insurance, and deductibles are due at the time of service, before you see the provider. Any overpayment's will be reimbursed after the account is settled with insurance and patient has stopped treatment for 90 days.
- If payment is made by check, and the check is returned for Non-Sufficient Funds (NSF) or Account Closure (AC), the patient or patient's responsible party will be responsible for the original check amount and in addition, a $25 service fee. Once notified by our office, payment must be made within 15 days, or the account may be turned over to our collection agency.
- Patients are responsible for notifying the front office of any changes regarding mailing address, phone number, and insurance coverage during or after the course of treatment.
- If claim is denied because the patient has not provided the correct insurance information, and new insurance information is provided after timely filing limitations have passed OR we are not contracted with the new insurance, the patient will be responsible for payment.
- If claims are not paid by your insurance plan within 90 days, the overdue amount will become the full responsibility of the patient and payment will be due at that time. It is the patient's responsibility to resolve outstanding issues with their insurance carrier and receive reimbursement, if applicable.
- We prefer a 48 hour notice but require a 24 hour notice to change or cancel a scheduled appointment. We charge **$60** for each missed appointment and/or late cancellation. This charge will not be billed to your insurance company and is the sole responsibility of the patient. Payment is due before your next appointment. If there are multiple missed or canceled appointments, we will move forward with scheduling only same day appointments.
  _____ *(Please initial)*
- OSS Physical & Hand Therapy does not accept liens or other third-party payers.
- Unresolved financial disputes for non-payment of fees for services rendered will result in discontinuation of services. The patient may be referred to another provider as necessary.
- If before or during the course of treatment there is **someone coming to your home** and providing physical therapy, hand therapy, injections, temperature, blood pressure, sugar, or bandage and wound checks, **it is required you inform the front office or your provider immediately.**

By signing below I have read, understand and acknowledge the polices listed above.

X

Signature Date

AUTHORIZATION & AGREEMENT

Authorization and Assignments

I hereby authorize OSS Physical & Hand Therapy to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release OSS Physical & Hand Therapy of any consequences thereof. In consideration of the services rendered to me by OSS Physical & Hand Therapy, I authorize and direct any insurance carrier to remit payment directly to OSS Physical & Hand Therapy.

SIGNATURE DATE

Agreement to Pay for Services Rendered

My signature below verifies that I have read and agree to the stated Clinic Policies, including an understanding that: Regardless of insurance coverage, I am responsible and liable for payment of all charges assessed for professional services rendered and any fees charged due to my failure to follow the stated Clinic Policies. I am responsible for any balance that my insurance company has not paid within 90 days. In the event that my insurance company remits payment to me for services rendered by OSS Physical & Hand Therapy, I will promptly forward payment to OSS. If it becomes necessary for OSS Physical & Hand Therapy to commence legal action for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs, and attorney fees.

SIGNATURE DATE

Insurance Benefits Acknowledgement

I have been made aware of my insurance benefits based on the information provided by my insurance company.

SIGNATURE DATE

Privacy Practice Agreement

By signing this form, you are only acknowledging that you have been provided access to our notice.

X

SIGNATURE DATE

You're done!

Now send us your completed forms.

Send to Burbank Send to Glendale

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