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

HISTORY & PHYSICAL

Name | Date of Birth

Reason for visit

Date of original symptoms/accident/surgery

Describe your symptoms

List any diagnostic testing (X-Ray, MRI, CT)

List any previous treatment of this issue

1 = NO PAIN 5 = MODERATE PAIN 10 = EXCRUCIATING

Describe your pain (1-10 rating) ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10

Describe your pain: ❍ Constant ❍ Frequent ❍ Occasional ❍ Intermittent

Have your symptoms changed in the last 4 weeks? ❍ Yes, they have improved ❍ No, there has been no change ❍ Yes, they are getting worse

What sports or other activities do you participate in?

List any significant prior surgeries or injuries

Please mark any you the following that you have or have had:

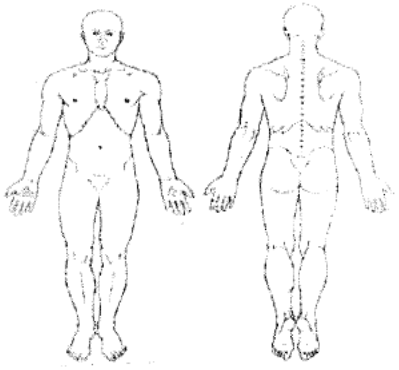
General Health

- ❍ Chest pain (Angina)
- ❍ Heart Attack or Surgery
- ❍ Rheumatic Fever
- ❍ Pacemaker
- ❍ Emphysema, Bronchitis
- ❍ Pregnancy
- ❍ Diabetes
- ❍ Cancer
- ❍ Stroke
- ❍ Osteoporosis
- ❍ Liver Problems
- ❍ Arthritis
- ❍ Artificial Joints
- ❍ Frequent Headaches
- ❍ Epilepsy or Seizures
- ❍ Kidney Problems
- ❍ High blood pressure
- ❍ Reactions to Heat/Cold
- ❍ Metal anywhere in your body
- ❍ Unexplained weakness, weight change, or shortness of breath
- ❍ Immune Deficiency Disease
- ❍ Hernia
- ❍ Dizziness/Fainting
- ❍ Fever/Chills
- ❍ Nausea/Vomiting
- ❍ MRSA or any Infectious Disease
- ❍ Difficulty with bowel & bladder function
- ❍ Problems with vision, hearing, speech
- ❍ Numbness in genital area/anal area
- ❍ Night sweats/night pain
- ❍ Other _____

Mental Health

- ❍ Anxiety
- ❍ Bipolar Disorder
- ❍ Depression
- ❍ Mental Illness
- ❍ Other _____

Please shade in painful areas below



Do you have any allergies? If yes, please list:

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

X _____

Signature Date

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

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

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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 form.

Send to Burbank Send to Glendale

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