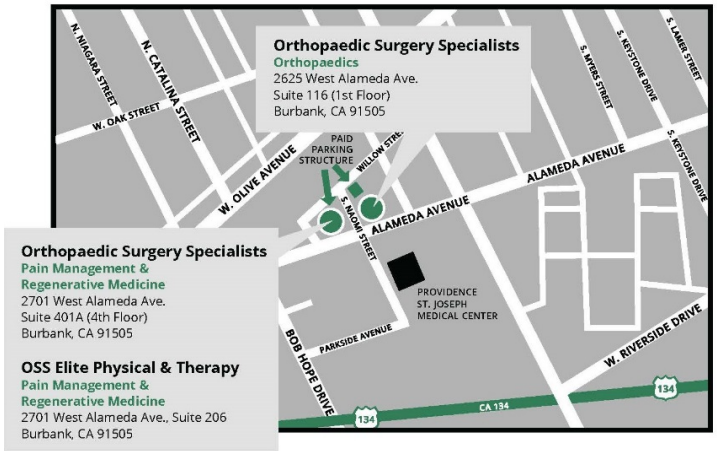
WELCOME

Before you come in for your visit at OSS Elite, please:

- ☐ Download, complete, and print this New Patient Form & Checklist packet. You can email the completed forms to info@ossphysicaltherapy.com (in subject heading write: Patient Form) and we will print them when you come in IF you are unable to print at home. Note: Your insurance and the type of injury may require that you complete additional forms in our office.
- ☐ Bring a valid photo ID.
- ☐ Bring a **prescription** or **referral form** from the doctor who is referring you to physical, hand or occupational therapy. The prescription / referral form must include the doctor name, the office telephone and your diagnosis. Most insurance companies do require a prescription. You may be able to receive physical therapy services for the short term without a prescription, however, if you are using health insurance, we highly RECOMMEND you present the prescription / referral from the start.
- ☐ Understand that OSS Elite accepts various forms of payment (cash, credit card) while using any one of these processing methods:
    - If using your health insurance, bring your health insurance card.
    - If using Workers' Compensation, bring your Workers' Compensation claim number and your case manager's name, telephone and email.
- ☐ Understand that before your first appointment, our OSS Elite Insurance Verification Coordinator will verify the therapy services that your insurance company will cover for your treatment. If you have any questions, please don't hesitate to call our office telephone at 818.579.2370 and press #1.
- ☐ Wear loose and comfortable clothes. Examples: shorts, sweats, and t-shirt.
- ☐ Know our location and contact information:
    - Our telephone: 818.579.2370
    - We are a separate office from OSS Orthopaedics and Pain Management.



Parking: Available in the parking structure next to each office building. Parking fees do apply; we do not validate. Street parking is available. Please note that if you park in the 2701 West Alameda building (location of OSS Elite), you can only pay by cash.

- ☐ If you need to cancel or reschedule, please give us at least 24 hours' notice.
- ☐ If you have any questions or want to know what to expect on your first visit, see our FAQ page.

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Physical & Hand Therapy

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 | Do you have Workers Comp? ❍ Yes ❍ No

In case of emergency, please notify: Name | Phone | Relationship

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

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MEDICATION RECORD

					FOR OFFICE USE ONLY		
Medication/Vitamin/Supplement	**Dose**	**Freq**	**Method** (Pill, shot, drops, etc)	**Time**	**Any change since**	**DOS**	**Initials**

I certify that this information is complete and true. I acknowledge that nondisclosure of medicinal 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 medicinal regimen.

X _____

Signature Date

2701 W Alameda Avenue • Suite #206 • Burbank CA 91505 • P (818) 579-2370 • P (818) 579-2371 • www.ossphysicaltherapy.com

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Physical & Hand Therapy

Patient Name: _____

Acct No. _____

HISTORY & PHYSICAL

Name | Height | Weight

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 PAIN

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?

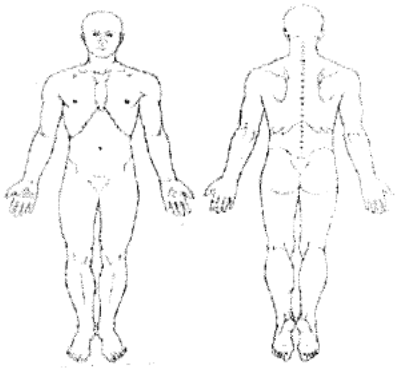
List any significant prior surgeries or injuries

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

- ❍ Chest pain (Angina)
- ❍ Heart Attack or Surgery
- ❍ Rheumatic Fever
- ❍ Pacemaker
- ❍ Emphysema, Bronchitis
- ❍ Pregnancy
- ❍ Diabetes
- ❍ Cancer
- ❍ Stroke
- ❍ Nervous Disorders
- ❍ 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 _____

_____

Please shade in painful areas below



Are you taking any medications? If yes, please list on medication profile.

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

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Physical & Hand Therapy

CLINIC POLICIES

Following are OSS Elite Physical & Hand Therapy office policies concerning your account and schedule:

- Claims will be billed to your insurance carrier, but all charges incurred will be the responsibility of the patient. Verification of benefits is not a guarantee of payment by the insurance company.
- The adult or parent accompanying a minor is financially responsible for all services provided by OSS Elite Physical & Hand Therapy.
- Co-payments, co-insurance, and deductibles are due at the time of service. We accept cash, check, Visa, Discover, American Express and MasterCard. We accept prepayment for coinsurance and deductibles. Any overpayments will be reimbursed after the account is settled with insurance and patient has ceased 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 in addition to 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. _____ *(Please initial)*
- 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 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.
- All appointments are scheduled at the front desk. Please direct all appointment related matters to the front desk.
- We require a 24 hour notice to change or cancel a scheduled appointment. We charge $50 for each missed appointment and/or late cancellation. This charge will not be billed to your insurance company and payment is due before your next appointment. _____ *(Please initial)*
- OSS Elite 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.