OCEANSIDE
PHYSICAL THERAPY
SPECIALIZING IN PELVIC FLOOR, OBSTETRICS + ORTHOPEDICS

Patient Information:

Name:_____

Address:_____

Phone Number(s):_____

Email:_____

Date of Birth:_____

Describe any symptoms/concerns that bring you to physical therapy today:

What do you wish to get out of your physical therapy sessions:

Are there additional providers that you are working with currently who you wish for us to communicate with:

118 Portsmouth Avenue, Suite B101, Stratham, NH 03885
・Phone: (603) 580-4494 ・Fax: (603) 580-4495
www.oceansidept.com oceansidept@comcast.net

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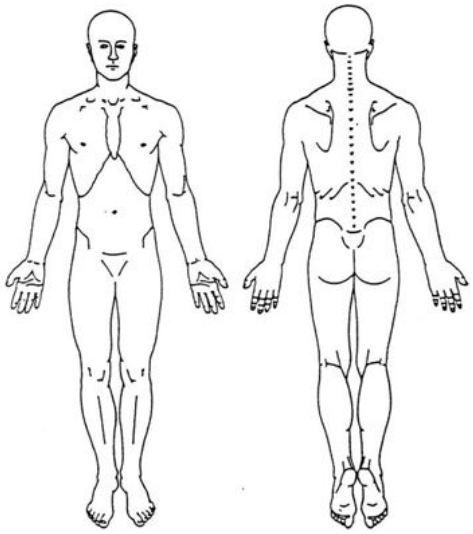
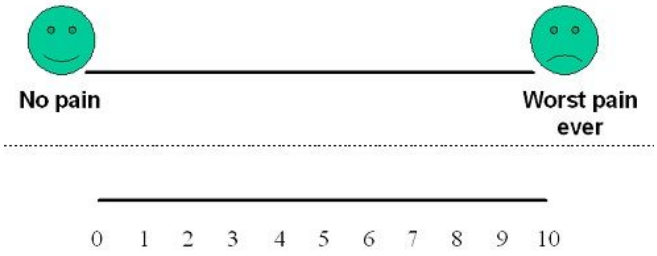
On the body diagram below, please indicate where your symptoms are currently located and rate your pain using the scale below.





When did your symptoms begin?

What makes your symptoms/pain worse?

What makes your symptoms/pain lessen?

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Medical History: Please list *all* current medical conditions that you have or are being treated by other providers:

1.	5.
2.	6.
3.	7.
4.	8.

Surgical History: Please list *all* past surgeries and the date of the surgery:

1.	4.
2.	5.
3.	6.

Medications: Please **list or attach** a list of all your current medications, dosages, and how often you take them. Please include any vitamins or herbal supplements you are taking as well. **Please note Medicare patients MUST provide a complete list for review.**

1.	5.
2.	6.
3.	7.
4.	8.

Overview of Systems: Have you experienced any of the following: (Circle any that apply.)

ALLERGIES:	
REPRODUCTIVE:	PCOS, Endometriosis, Irregular Cycles, Other Dysfunction:
ENDOCRINE:	Thyroid dysfunction, energy deficits, challenges with weight gain/loss
ENT:	Ringing in ears, Decreased Hearing, Ear pain or drainage Runny nose, Congestion, Sneezing, Sore throat, swallowing difficulty
CARDIOVASCULAR:	Chest pain (resting or with exertion), Palpitations (Heart beats fast or funny), Swelling, Swollen ankles, Leg pain when walking, Fainting or Blacking out, High Blood Pressure
RESPIRATORY:	Cough (day or night), SOB (rest or with exertion), sputum, and history of asthma / wheezing, bronchitis, pneumonia

MUSCULOSKELETAL:	Pain or swelling in muscles or joints, weakness Arthritis, Osteoporosis, Bone fracture / joint injury, Gout
HEM/LYMPH:	Easy Bleeding or bruising, Lumps or bumps in neck, armpits, groin, breasts or testicles.
NEUROLOGICAL:	Numbness and Tingling, Fainting, Blackouts, Abnormal Jerking, Repetitive movements, history of seizures, tremors, tics
PSYCHIATRIC:	Anxiety, depression, moodiness, paranoia, or phobias Diagnoses:
SLEEP	Average hours/night: Do you have difficulty with sleep: YES NO
SKIN:	Acne, Dry, Flaky, Peeling, Rash, Redness, Itching, Recent change in moles/lesions/or birthmarks. Describe color / location / size:
PREGNANCY:	Number of pregnancies: Number of Deliveries: Notes:
ANY HISTORY OF TRAUMA:	

When was your most recent yearly check up:_____

Special Diagnostics Test: Please check all that apply:

• EMG	• Pudendal Nerve Test
• MRI	• Anal Ultrasound- Manometry
• Cystoscope	• Defecation Proctogram Study
• Bladder Stress Test	• Urodynamic Testing
• Colonoscopy	• Food Allergy or Sensitivity Testing
• Urethral Dilations	• Other:

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Insurance Information:

Insurance Carrier:_____

ID #:_____

Subscriber's Name & Date of Birth:_____

Referring Physician:	**Primary Care Physician:**
Name:_____	Name:_____
Practice Name:_____	Practice Name:_____
Phone:_____	Phone:_____

Due to privacy regulations, we require your permission to leave messages (such as appointment reminders) on your answering machine or with any individual who answers the number you provide, identifying ourselves as "Oceanside Physical Therapy". Do we have permission to leave such messages? _____ Yes _____No Initials:_____

Do we have permission to send non-encrypted emails regarding scheduling or treatment to the email address provided? ____Yes____No Initials:____

Do we have permission to send non-encrypted text messages regarding scheduling or cancellations to the mobile number provided? ____Yes____No Initials:____

Do we have permission to send you our practice newsletter via email to inform you of events and exercises classes being offered at Oceanside? ____Yes _____No Initials:_____

Patient Name (Please Print):_____

Patient Signature:_____

Signature of parent or guardian (if applicable):_____

Date:_____

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HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name:_____Date:_____

Signature:_____

Relationship to patient:_____

Release to additional parties:_____

_____

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Cancellation Policy

Please provide our office with 24-hour notice when changing or cancelling an appointment. Please understand we are working in a healthcare system that values time over quality. We have taken a stand against this model and value quality, but never at the expense of time. We need time to listen and help you navigate this confusing healthcare system. We allot a significant amount of time for one-on-one sessions with highly skilled therapists. Therefore, we have a $50 cancellation fee for all visits. Credit or HSA card information is taken at the time of scheduling, the full evaluation fee of $150 will be processed if the appointment is cancelled within 24 hours of the session or is not attended.

We realize that emergencies and sickness arise and are sometimes unavoidable; however, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level.

Appointment reminders are set up at your first appointment and are sent out 48 hours prior to your appointment. Please listen to the time and date given or carefully read the reminder email. If the information is not what you are expecting or if you cannot attend, please contact us promptly so we can adjust the schedule accordingly.

Thank you for understanding this policy as it allows us to continue in our mission to provide care that is highly specialized, individualized and outside the norm of many physical therapy clinics.

Signature_____

Date:_____

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Billing and Insurance Policy

The insurance system can be confusing and plans vary widely in physical therapy coverage. Oceanside Physical Therapy will complete a preliminary benefit check on your behalf, but the information we have access to is not always current or accurate and coverage IS NOT a guarantee of payment by your insurance company. You are financially responsible for charges for services rendered. We have the following policies in place to ensure we are able to provide the highest-quality, individualized care to our patients while working within the constraints of the current healthcare system. Please review these policies carefully. All patients are subject to these terms.

PAYMENT: Payment is due at time of service. This includes copays, deductibles or coinsurances that apply to your insurance plan. When making your first appointment, OPT will ask for and securely store credit card, HSA, or FSA information. Should your account go unpaid for more than **30 days**, we will charge the balance to the card on file. We will make reasonable efforts to notify you of pending balances prior to charging your card.

- It is OPT's policy to collect an estimated amount toward your deductible or coinsurance at every visit. We typically underestimate these payments and will collect a small balance once the final amount is determined by your insurance company. Should your insurance approve an amount lower than what we have collected, we will apply the balance to your account.
- If your insurance denies a claim, we will do our best to resolve the issue and reprocess the claim. If we are unable to get the claim approved, you are responsible for the charges at the reduced out-of-network rates as outlined below. **Note for Medicare patients: If you exceed your PT benefit in a calendar year, per Medicare's policy we CANNOT legally continue providing services on a cash basis.*
- OPT reserves the right to discontinue providing services to patients with outstanding balances until an agreement for payment in full or by installments is made.

OUT OF NETWORK INSURANCE: Payment is due in full at each visit per our standard out of network rates ($150 for evaluation, $125 for subsequent visits). In the event your insurance company reimburses you directly for more than we collected, we are **legally obligated** to collect the balance of the reimbursed amount.

INSURANCE: It is **your responsibility** to understand your insurance plan's provisions for orthopedic or pelvic floor physical therapy, including, but not limited to, any referral or authorization requirements and ensure those requirements are met **PRIOR** to your first appointment.

CHANGES IN INSURANCE: It is your responsibility to inform OPT of **ANY** changes to your insurance plan or provider **PRIOR** to your next scheduled visit in order to ensure continued coverage and that any new requirements for your plan (referrals, authorizations, etc) are in place before your visit.

I have read the above policies and understand that I am financially responsible for all charges for services provided.
**Signature below authorizes OPT for all credit card transactions for services provided.*

Patient name:_____Date:_____

Signature:_____

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