Catalyst Orthopedic & Sports Physical Therapy, LLC

First Name ____________________ Date of injury/onset __________ Today's Date _____________

Last Name ____________________ Date of Birth ______________ Age ________

Social Security: _________-______-__________ Sex: M F Marital Status: S M D W

Address ____

City ___________________________ State ________ Zip __________

Employer: ____

Home Phone: ( ) ______-___________ Work Phone: ( ) __________-_____________

Email address: ____

Injury Area: _________________________ Accident Related? Y N If yes, Auto Work

Referring Physician: _______________________________________Phone ( ) ______-______________

Primary Insurance __________________________________Insured Name __________________________

Group # _____________________Policy # ____

Emergency Contact __________________________________Phone: ( ) ________-_________________

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

How did you hear about Catalyst Orthopedic & Sports Physical Therapy? ___________________________

Please Initial after reading statements:

1. **Consent to Treatment:** I consent to rehabilitation and related services at Catalyst Orthopedic & Sports Physical Therapy, LLC. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _________

2. **Treatment of Minor**: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. __________

3. **Liability:** I know and agree that Catalyst Orthopedic & Sports Physical Therapy, LLC is not responsible for loss or damage to personal valuables. __________

4. **Authorization of Payment:** I hereby assign all benefits directly to Catalyst Orthopedic & Sports Physical Therapy, LLC and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. ___________

5. **Consent for Information Release:** I give Catalyst Orthopedic & Sports Physical Therapy, LLC permission to release my personal injury information to Axis trainers in order to help modify my exercise program. ___________

Patient Signature: ____Date: _________________________

Catalyst Orthopedic & Sports Physical Therapy, LLC

Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical report.

Name:___________________________________ D.O.B.:____/____/_____

Referring Physician:_________________________ Phone:____

Emergency Contact:_________________________ Phone:____

Date of Last General Health Check-up:____/____/____ Occupation:____________________________________

Hospitalizations (Dates & Reasons):____

Operations (Dates & Reasons):____

Have you had Surgery for this Injury? Yes No Type of Surgery/Dates:________________________________

Pain (please draw a vertical line where you would rate your pain intensity): 0---------------5---------------10

No Pain Maximum Pain Tolerable

My pain can be described as: (please circle all that apply):

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Current Medications: ____

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode? If yes, please specify.

	Yes	No		Yes	No
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you now have, or have you ever had, any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Heart Surgery	___	___	Weight Loss/Energy Loss	___	___
Blood Clot/Emboli	___	___	Hernia	___	___
Stroke/TIA	___	___	Epilepsy/Seizures	___	___
Allergies	___	___	Thyroid Trouble/Goiter	___	___
Pins or Metal Implants	___	___	Incontinence	___	___
Joint Replacement (any joint)	___	___	Bowel or Bladder Problems	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Infectious Diseases	___	___	Shoulder Injury/Surgery	___	___
Cancer/Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis/Swollen Joints	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulty	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Do you smoke?	___	___	Multiple Sclerosis/Parkinson's	___	___
Latex Sensitivity/Allergy	___	___	Are you pregnant?	___	___

Family History: (Please circle all that apply to any member of your immediate family)

Diabetes Heart Disease Arthritis Adverse Reaction to Anesthesia

Patient/Guardian Signature:________________________________ Date:_____/_____/_____

PT Initials:_____________ Date:_____/_____/_____

Catalyst Orthopedic & Sports Physical Therapy, LLC

Patient Responsibility and Policy Form

Private Insurance Patients:

1. Co-Payments are due at the time of service (each session).
2. Patients should schedule follow-up appointments every 30 days with their Physician.
3. There will be a $35 fee for any cancellation made less than 24 hours prior to your appointment time.
4. The treating therapist has the discretion not to treat patients that are more than 15 minutes late for their scheduled appointment.
5. Patients are encouraged to schedule appointments 2-3 weeks in advance. (We cannot guarantee your regularly scheduled appointment times.)
6. Authorization may be required.
7. It is the patient's responsibility to now his/her insurance plan. If a referral is needed the patient should have it upon their appointment time.

Workers Compensation & Automobile Accident Patients:

1. Patients should schedule follow-up appointments every 30 days with their Physician.
2. There will be a $35 fee for any cancellation made less than 24 hours prior to your appointment time.
3. The treating therapist has the discretion not to treat any patients that are more than 15 minutes late for their scheduled appointment.
4. Patients are encouraged to schedule appointments 2-3 weeks in advance. (We cannot guarantee your regularly scheduled appointment times.)
5. It is recommended that you obtain an attorney to help assist you in your case (Recommendations can be provided at your request).

Patient Signature:______________________________ Date:____/____/____

Catalyst Orthopedic & Sports Physical Therapy, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Catalyst Orthopedic & Sports Physical Therapy, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Catalyst Orthopedic & Sports Physical Therapy, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Catalyst Orthopedic & Sports Physical Therapy, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Jason A. Nunn, DPT, CSCS

9030 State Route 108, Suite B

Columbia, MD 21045

(410) 884-9080

With this consent, Catalyst Orthopedic & Sports Physical Therapy, LLC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Catalyst Orthopedic & Sports Physical Therapy, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Catalyst Orthopedic & Sports Physical Therapy, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Catalyst Orthopedic & Sports Physical Therapy, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Catalyst Orthopedic & Sports Physical Therapy, LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Catalyst Orthopedic & Sports Physical Therapy, LLC may decline to provide treatment to me.

Signed by:______________________________ Date ___/___/___ Relationship to Patient:_____________________

Patient's Name (print):____

Name of Legal Guardian, if applicable (print):____

Acknowledgement of Privacy Practices

The Notice of Privacy Practices was offered to me and I have been provided an opportunity to review it.

I am aware that I am entitled to a copy of this Notice and that I have the opportunity to review it at any time, upon my request.

Name:_______________________________ Date of Birth:____/____/____

Signature:____________________________ Date____/____/____