Thank you for scheduling with our office.

If you are a **NEW patient or have not been seen in the office in 2+ years**:

- Please complete the forms attached.
- Please arrive to your appointment between 10-15 minutes early with these forms completed, your insurance cards and photo id.
- Also be sure to bring your co-pay at this time.
- If you have had any diagnostic studies performed such as x-rays, MRI's, EMG's, etc **you MUST bring in the copies of these tests at the time of your appointment as well as a CD of the images.**
    - Failure to do so may result in your appointment being rescheduled or these tests may need to be repeated.

If you need to reschedule your appointment, please call our office at **419-427-1984**, press **224**.

If you have any questions please feel free to call. Thanks and have great day.

Please be sure to check out our new patient portal by clicking on the blue patient portal button at the top right of the website.

- On the portal you can request appointments and pay your bills online. Check it out today!

Thank you
Northwest Ohio Orthopedics and Sports Medicine

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Rehabilitation Directors
Joseph Distel, PT, DPT
Larry Adolph, PT, DPT
Cara Wagner, PT

Rehabilitative Therapy

Welcome

We would like to welcome you to Northwest Ohio Orthopedics and Sports Medicine (NWO) as a patient in our Rehabilitative Therapy Department. It is our priority to make your experience with us a positive one. Please ask a staff member to clarify any portion of this information that you do not fully understand. To schedule an appointment or if you have any questions, please feel free to call the numbers listed.

Findlay Office Phone number: 419-427-1984, ext. 222
Tiffin Office Phone Number: 419-443-1429, ext 235

Scheduling

Scheduling your appointments is an important aspect of your care, and we do our best to accommodate the personal needs of our patients. However, with the limited number of visits available in a day, it is best that you make your appointments as far in advance as possible. Recovery is best accomplished by keeping your scheduled appointments. If at any time, you are unable to make your appointment, please call to reschedule. If you fail to show for an appointment, you will be called to reschedule within 24 hours. If you have three (3) consecutive "no shows", you will be discharged from the therapy program and will need to see your physician before returning.

Teamwork

Here at NWO, you will be assigned to a team of licensed professionals. Your initial visit will include an evaluation of your injury. A comprehensive therapy program will then be developed for you based upon the latest physical or occupational therapy advances. Throughout your program, you will be monitored and progressed as you recover and your function improves. Our ultimate goal for you is to be independent in either at home exercises or our aftercare program. Our Aftercare program is a specially priced three, six, or twelve month program for our discharged patients striving for continued fitness at our own fitness facility. It is custom designed and partly based on your prior, formal therapy program.

Insurance Benefits

It is essential that you understand your insurance benefits as they relate to physical/occupational therapy. Your insurance may have provisions within the policy that include such things as visit limits, monetary maximums, pre-authorization and pre-certification requirements. Your insurance may combine benefits along with other therapies such as chiropractic and speech therapy; reducing the number of visits available to you. Durable medical equipment (DME's, i.e. braces, splints, etc.) may also require pre-certification from your insurance separate from your physical therapy treatments. It is your responsibility to know your benefits and limitations as it is a contract between you, your employer, and insurance company. Please contact your insurance company, prior to services, to obtain your benefit information. You will be financially responsible for services not covered by your insurance.

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Information (Please print and use in pen)

Legal Last Name:	Legal First Name:	Middle Name:	SSN:	
Address:	City:	Sate:	Zip:	Email Address:
Home Telephone:	Cell Phone:	Other Phone:	Gender: □ M □ F	Status: □Married □Single □Widowed □Divorced
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: □ Yes □No	Auto Related: □ Yes □ No	

If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No Name of Facility_____

If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No
If so, do you know if you have exceeded the Medicare cap? □ Yes □ No

If Medicare, are you currently receiving Home Health Services: □ Yes □ No Type of service:
If yes, Name of Agency:_____ Date of Last Service:

Physician Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here:
May we send medical information to your PCP: □ Yes □ No		City/State of Referring Physician:

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ Other _____

Mother's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

Emergency Contact

Contact Name:	Phone:	Relationship:

Health Care Primary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyy):	SSN:	
Employers Name:	Relationship to patient: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □ Other_____		

Authorization: I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize NWO, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

_____

_____

Patient/Guardian:_____Date:_____

MEDICAL QUESTIONNAIRE (PG. 1)

Patient Legal Name (Print) _____ Date _____

Age: _____ ❑F ❑M Dominant Hand: ❑R ❑L Height/Weight _____/_____

Family Doctor: _____ City: _____ Who requested you visit this office? _____

What is the main reason for this visit? ❑Pain ❑Numbness ❑Weakness ❑Swelling ❑Stiffness ❑Other

What body part is involved? Please mark below.

☐ **Neck**; radiates to: ☐ RT Arm ☐ LT Arm	☐ **Shoulder** ☐ RT ☐ LT	☐ **Elbow** ☐ RT ☐ LT	☐ **Hand** ☐ RT ☐ LT
☐ **Arm** ☐ RT ☐ LT	☐ **Wrist** ☐ RT ☐ LT	☐ **Back**; radiates to: ☐ RT Leg ☐ LT Leg	☐ **Pelvis** ☐ RT ☐ LT	☐ **Hip** ☐ RT ☐ LT
☐ **Knee** ☐ RT ☐ LT	☐ **Foot** ☐ RT ☐ LT	☐ **Ankle** ☐ RT ☐ LT	☐ **Finger** ☐ RT T 2 3 4 5 ☐ LT	☐ **Toe** ☐ RT B 2 3 4 5 ☐ LT

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years. Have you had a problem like this before? ❑Y ❑N

In this section, check ONE Box which best describes how your problem started. Please answer the questions below the boxes you check.

❑ **No Injury** (Onset was: ❑ Gradual ❑ Sudden)
Why do you think it started?

❑ **Injury** (❑ Accident-NOT auto or work ❑ Sport)
Date: _____ When/How did it happen?
What sport and school? _____

❑ **Injury at Work** Date: _____
From a ❑ Lift ❑ Twist ❑ Fall ❑ Bend
❑ Pull ❑ Reach

❑ **Work Related, but NO Injury**
Date: _____ How did your job cause this?

❑ **Auto Accident** Date: _____
How was your car hit?

Answer/Comment

_____
_____
_____
_____
_____
_____
_____
_____

*****On a scale of 0-10 (10 is the worst), how **severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

*****What is the **quality** of your pain? ❑Sharp ❑Dull ❑Stabbing ❑Throbbing ❑Aching ❑Burning

*****Is your pain: ❑Constant ❑Intermittent (Comes & Goes)

Does your pain awake you from sleep? ❑Y ❑N

Do you have: ❑Numbness ❑Weakness ❑Swelling
❑Stiffness ❑Bruising ❑Loss of control of bowel or bladder?

Since your problem started, is it: ❑Getting Better ❑Getting Worse ❑Unchanged

What makes your symptoms **worse**? ❑Standing ❑Walking ❑Lifting ❑Exercise ❑Twisting ❑Bending
❑Lying in Bed ❑Squatting ❑Kneeling ❑Stairs ❑Sitting ❑Coughing ❑Sneezing

What makes your symptoms **better**? ❑Rest ❑Elevation ❑Ice ❑Heat ❑Other

What medications are you taking now or have you taken previously for this problem? _____

Have you had any of these treatments? ❑Injection ❑Brace ❑PT/OT ❑Cane/Crutch

Were you seen in the Emergency Room for this? ❑Y ❑N If yes, Where? _____

What tests/scans have you had for this problem? ❑X-Rays ❑MRI ❑CAT scan ❑Bone Scan ❑Nerve Test (EMG/NCV)

Have you previously had surgery in this same general area? ❑Y ❑N (If Yes, List Below)

Date: _____ Procedure: _____ Surgeon: _____

Date: _____ Procedure: _____ Surgeon: _____

Current work status? ❑Regular ❑Retired ❑Light duty (How long? _____)
❑Not working due to this problem (Since when? _____) ❑Disabled

Are you currently receiving or plan to apply for: ☐ Disability ☐ Workman's Comp ☐ Unemployment ☐ None

REVIEW OF SYSTEMS (PG 2)

Patient Legal Name (Print) _____ Date _____

1. **M/S** Have you had a **prior problem** with this same Orthopedic condition in the past? ❑Y ❑N

*Please explain: _____

Do you have: ❑Joint pain or swelling ❑Back Pain ❑Gout ❑Rheumatoid Arthritis ❑Osteoporosis

❑Prior Fracture (which bone) _____ ❑None of the above

Have you had a Bone Density Scan for Osteoporosis within the last 2 years? ❑Y ❑N

Have you had any of these symptoms? If not, mark NONE.		**NONE**	**Year**	**Explanation/Comments**
2. **GI**	❑Heartburn/Ulcers ❑Nausea/Vomiting ❑Blood in Stool ❑Hepatitis ❑Liver Disease	☐		
3. **ENDO**	❑Thyroid Disease ❑Heat/Cold Intolerance	☐		
4. **CON**	❑Weight Loss ❑Frequent Fever ❑Loss of Appetite	❑		
5. **EYE**	❑ Blurred Vision ❑Double Vision ❑Loss of Vision	❑		
6. **ENT**	❑Hearing Loss ❑Hoarseness ❑Trouble Swallowing	❑		
7. **CV**	❑Chest Pain ❑Palpitations	❑		
8. **RS**	❑Chronic Cough ❑Shortness of Breath	❑		
9. **GU**	❑Painful Urination ❑Blood in Urine ❑Kidney Problems	❑		
10. **SK**	❑Frequent Rashes ❑Skin Ulcers ❑Lumps ❑Psoriasis	❑		
11. **NEU**	❑Headaches ❑Dizziness ❑Seizures	❑		
12. **PSY**	❑Depression ❑Drug/Alcohol addiction ❑Sleep disorder	❑		
13. **HEM**	❑Easy Bleeding ❑Easy Bruising ❑Anemia	❑		

14. **Are you ALLERGIC to any medications, metals, soaps, dyes, etc.?** ❑Y ❑N If yes, please list and describe reaction?

_____

Medical History

What medications do you take? ❑NONE Please list with dosage: _____

_____

Have you had cortisone within the past year? ☐Y ☐N

Are you a diabetic? ❑Y ❑N Treatment: ❑Insulin ❑Oral Meds ❑ Diet ❑NONE

Are you taking, or have you ever taken, blood thinners? ❑Y ❑N If yes, which one? _____

Past Surgical History: What operations have you had and when? ❑NONE _____

Have you ever had a reaction to anesthesia? ❑Y ❑N

Previous hospitalizations, other than for surgery? ❑NONE _____

Past/Current health problems or diagnosis _____

Have you ever had: ❑Heart Attack (year) _____ ❑High Blood Pressure ❑Blood Clots (year) _____ ❑Stroke

❑Heart Failure ❑Ankle Swelling ❑Kidney Failure ❑Asthma ❑Sulfa Allergy

❑Aspirin Sensitivity ☐ Stomach Ulcers ❑Bleeding Ulcers ❑Stomach-ache/taking Anti-Inflammatory

(including Advil/Aleve) Name of the Anti-Inflammatory have you had a problem with: _____

❑Cancer (Type) _____ ❑MS ❑Polio ❑ **NONE** of the above

Family History

Have any **direct** relatives had any of the following disorders? If so, which relative?

❑ Diabetes_____ ❑ High Blood Pressure_____ ❑ Heart Disease_____

❑ Rheumatoid Arthritis_____ ❑ **NONE** of the above

Social History

Do you use Tobacco? ❑Y ❑N Packs/ day _____ Alcohol? ❑Y ❑N How often? ❑Daily ❑ _____/week

Do you use Drugs? ☐Y ☐N Marital History: M S D W How many people live with you? _____ ☐ Student

Occupation: _____ Employer: _____ Do you like your job? ☐ Y ☐ N

Do you plan to be working 6 months from now? ☐Y ☐N

****Please Sign:** The information contained on these forms is accurate to the best of my knowledge. **Patient Signature:** _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

EXPLANATION OF CONDITION

Patient Legal Name: _____
First MI Last

CONDITION/ACCIDENT/INJURY INFORMATION

Symptoms first begin on: _____/_____/_____ or have been experiencing for _____days _____ weeks _____months _____ years.

What symptoms are you experiencing? _____

_____

What body parts are affected? _____

_____

Have any of these body parts been injured before? YES NO If yes, please describe: _____

_____

What medications are you currently taking? _____

_____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). _____

_____

_____

Will you seek payment from another party? YES NO If yes, who? BWC MVA Other

If an attorney is involved, please provide name, address, and phone number: _____

_____

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _____/_____/_____ State Accident Occurred: _____ Time: _____

Auto Insurance Name: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____ Name of Insured: _____

Claim Number: _____ Policy Number: _____ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

AUTHORIZATION

I, with my signature, authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: _____ Date: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

FINANCIAL POLICY

Regarding Your Insurance:
Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.) **is the responsibility of the undersigned responsible party**. If NWO is not in your insurance plan, **the undersigned responsible party is responsible for all charges**. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit**. In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:
We accept cash, check, and credit/debit card payments. Credit cards and/or checks can be "kept on file" for your convenience. This information is securely stored by an authorized vendor. Notification will be given before a payment transaction is performed. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. A fee of $30.00 will be applied and collected from your account if payment is returned non-paid.

Past Due Accounts:
If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

Orthopedic, Family Medicine, Chiropractic, Podiatry and Pain Management No-Show Fee:
Missed or non-cancelled appointments will result in a $25.00 no-show fee. Chiropractic appointments must be cancelled within 24 hours of scheduled appointment.

Imaging No-Show Fee:
Cancellation within 24 hours prior to a scheduled MRI or CT will be subject to a $50.00 no-show fee.

Durable Medical Equipment:
If you need to return a product, and you are the original purchaser, you need to do so **within 10 days of receiving**. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

FMLA, Disability, and Drug Company Assistance Forms:
Any patient needing forms filled out by our office will incur a one time $15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Patient Name: _____

_____ _____
Signature of Responsible Party **Date**

Printed Name of Responsible Party: _____

Relationship to Patient (e.g., self, parent/guardian): _____

INSURANCE BENEFITS

It is essential that you understand your insurance benefits as they relate to physical/occupational therapy. Your insurance may have provisions within the policy that include such things as visit limits, monetary maximums, pre-authorization and pre-certification requirements. Your insurance may combine benefits along with other therapies such as chiropractic and speech therapy; reducing the number of visits available to you. Durable medical equipment (DME's, i.e. braces, splints, etc.) may also require prior authorization from your insurance separate from your physical therapy treatments. It is your responsibility to know your benefits and limitations as it is a contract between you, your employer, and insurance company. You will be financially responsible for services not covered by your insurance or if you exceed your maximum benefits.

Please contact your insurance company prior to services to obtain your benefit information. There is usually a phone number on the back of your insurance ID card to call for benefits. We have provided a template on what to ask the benefits specialist at your insurance company. Please write and/or circle appropriate answer.

Patient's Legal Name _____ Subscriber Name _____
Signature

Insurance _____Subscriber ID _____ Date:_____

Is NWO In-Network? Yes No (NWO's Tax ID: 34-1963354)

Therapy Benefits:

Are physical, occupational, and chiropractic benefits combined? Yes No

Number of physical therapy visits allowed per year? _____

Number of occupational therapy visits allowed per year? _____

Number of chiropractic visits allowed per year?_____

Prior authorization for services required prior or during therapy? Yes _____
_____ No

Have you received any therapy during the current year? Yes _____
_____ No

Is there a dollar amount maximum for therapy visits per year? Yes - $_____ No

Therapy Co-pay? Yes - $_____ No

Does a deductible need to be met? Yes - $_____ No

Therapy Co-Insurance? Yes - $_____ No

Is there a limit to the number of therapy units per day? Yes - #_____ No

Prior authorization required for any DME? Yes_____ No

Is there a limit to the number durable medical equipment (DME) given? Yes_____ No

Other Notes_____

Please mail / fax this form to NWO, Attn: Case Mgm., prior to your first or next visit. Fax: 419-427-3020.

Thank you for taking the time to be knowledgeable about your benefits. This will help ensure claims are paid quickly, effectively, and you are not surprised as to what your benefits entail.

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Consent for Minor to Receive Treatment

I, the parent/guardian of _____, give consent for my child to receive the following types of medical services at the Northwest Ohio Orthopedics & Sports Medicine, Inc. ("NWO"):.

_____

_____ _____ that could include:

- ❑ Imaging services: CT, MRI, Ultrasound
- ❑ Chiropractic Care
- ❑ Physical/Occupational Therapy/ DME
- ❑ Pain Management

❑ **A parent will be present for all visits**

I understand that this consent form will be good until _____.

Except to the extent that the law requires my child's signed consent prior to disclosure, I understand that I will be entitled access to medical information concerning services provided to my child pursuant to this consent. I understand that nothing in this consent affects the ability of the NWO to provide medical services to my child without my consent to the extent expressly permitted under Ohio law.

I understand that I will be responsible for payment for any charges relating to services provided to my child pursuant to this consent, to the extent that such services are not covered in full by insurance or other third-party payor covering my child. NWO may release information regarding treatment to third party payers for billing purposes.

_____ _____

Signature of Parent / Legal Guardian Date

NOTARY PUBLIC SIGNATURE / STAMP / SEAL REQUIRED

State of Ohio
County of _____

Subscribed and sworn to me this _____ day of _____ 20 _____

Signature: _____
My commission expires: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Medication List

Patient Name: _____ Date of Birth: _____

What medications do you currently take? (Including over the counter, vitamins/supplements)

☐ None

Name of Medication	Dosage	Doctor That Prescribed

Patient/Guardian Signature: _____ Date: _____