JOINT RESTORATION CENTER

New Patient Paperwork

Demographics

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ ❑ home ❑ mobile | Secondary Phone: _____ ❑ home ❑ mobile

Email: _____ Social Security Number: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Medical History

Medications (Including any over-the-counter medications, vitamins or supplements):

_____

_____

_____

_____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes, please list: _____

Are you allergic to eggs, chicken, poultry, fish, shellfish, iodine, or contrast dye? ❑ Yes ❑ No

If yes, please list: _____

Have you or a close family member EVER been diagnosed with any of the following conditions (check all that apply to you and circle those that apply to your family history)?

❑ Cancer	❑ Depression	❑ Thyroid Problems
❑ Heart Problems	❑ Lung Problems	❑ Diabetes
❑ Chest Pain/Angina	❑ Osteoporosis	❑ High Blood Pressure
❑ Asthma	❑ Multiple Sclerosis	❑ Circulation Problems
❑ Rheumatoid Arthritis	❑ Epilepsy	❑ Blood Clots
❑ Osteoarthritis	❑ Stroke	❑ Ulcers
❑ Bladder/Urinary Tract Infection	❑ Anemia	❑ Kidney Problems
❑ Chemical Dependency (i.e., alcoholism)	❑ Bone or Joint Infection	❑ Hepatitis
❑ Sexually Transmitted Disease/HIV	❑ Pelvic Inflammatory Disease	❑ Liver Problems

Other: _____

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Have you had any surgeries (check all that apply)?

❑ Heart Surgery ❑ Aneurysm Repair ❑ Back Surgery
❑ Pacemaker/Defibrillator ❑ Knee Replacement ❑ Other Knee Surgery
❑ Hip Replacement ❑ Spinal Fusion ❑ Hysterectomy
❑ Other _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ Fatigue ❑ Numbness or Tingling ❑ Weight Loss/Gain
❑ Fever/Chills/Sweats ❑ Muscle Weakness ❑ Headaches
❑ Nausea/Vomiting ❑ Dizziness/Lightheadedness ❑ Shortness of Breath
❑ Cough ❑ Heartburn/Indigestion ❑ Fainting
❑ Difficulty Maintaining Balance ❑ Difficulty Swallowing ❑ Chest Pain
❑ Changes in Bowel or Bladder Function ❑ _____ ❑ _____

Social History

Tobacco Use: ❑ Yes ❑ No Frequency: _____

Alcohol Use: ❑ Yes ❑ No Frequency: _____

Primary Complaint

What are we seeing you for today? _____
What date (roughly) did your present symptoms start? _____
What do you think caused your symptoms? _____
Your symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same
Treatment received so far for this problem (chiropractic, injections, etc.)
_____
_____
Did any of these treatments help? ❑ Yes ❑ No
Please list special tests performed for this problem (x-ray, MRI, labs, etc.)
_____
_____

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____
The best your pain has been during the past week: _____
The worst your pain has been during the past week: _____

Do you exercise regularly? ❑ Yes ❑ No
If so, what type? _____
Occupation, including activities required for your job:
_____
_____

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WOMAC Survey Form

Instructions: In Sections A, B, and C, questions will be asked about your hip or knee pain. Please mark each response with an X. If you are unsure about how to answer a question, please give the best answer you can.

A. Think about the pain you felt in your hip/knee during the last 2 weeks.

How much pain do you have?	None (0)	Mild (1)	Moderate (2)	Severe (3)	Extreme (4)
1. Walking on a flat surface	☐	☐	☐	☐	☐
2. Going up and down stairs	☐	☐	☐	☐	☐
3. At night while in bed, pain disturbs sleep	☐	☐	☐	☐	☐
4. Sitting or lying	☐	☐	☐	☐	☐
5. Standing upright	☐	☐	☐	☐	☐

B. Think about the stiffness (not pain) you have in your hip/knee during the last 48 hours. Stiffness is a sensation of decreased ease in moving your joint.

	None (0)	Mild (1)	Moderate (2)	Severe (3)	Extreme (4)
6. How severe is your stiffness after first awakening in the morning?	☐	☐	☐	☐	☐
7. How severe is your stiffness after sitting, lying, or resting in the day?	☐	☐	☐	☐	☐

C. Think about the difficulty you had in doing the following daily physical activities due to your hip/knee during the last 48 hours. By this we mean your ability to move around and look after yourself.

What degree of difficulty do you have?	None (0)	Mild (1)	Moderate (2)	Severe (3)	Extreme (4)
8. Descending stairs	☐	☐	☐	☐	☐
9. Ascending stairs	☐	☐	☐	☐	☐
10. Rising from sitting	☐	☐	☐	☐	☐
11. Standing	☐	☐	☐	☐	☐
12. Bending to the floor	☐	☐	☐	☐	☐
13. Walking on flat surfaces	☐	☐	☐	☐	☐
14. Getting in and out of a car, or on or off a bus	☐	☐	☐	☐	☐
15. Going shopping	☐	☐	☐	☐	☐
16. Putting on your socks or stockings	☐	☐	☐	☐	☐
17. Rising from the bed	☐	☐	☐	☐	☐
18. Taking off your socks or stockings	☐	☐	☐	☐	☐
19. Lying in bed	☐	☐	☐	☐	☐
20. Getting in or out of the bath	☐	☐	☐	☐	☐
21. Sitting	☐	☐	☐	☐	☐
22. Getting on or off the toilet	☐	☐	☐	☐	☐
23. Performing heavy domestic duties	☐	☐	☐	☐	☐
24 Performing light domestic duties	☐	☐	☐	☐	☐

TOTAL SCORE: _____

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Financial Information

Who will be financially responsible? ❑ Self ❑ Other

Name: _____ Phone: _____ ❑ home ❑ mobile

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance: _____

Member ID: _____ Group Number (if applicable): _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Secondary Insurance

Member ID: _____ Group Number (if applicable): _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

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Consent for X-Rays

Adult Male:

X-Ray Consent Form Patient Consent to X-Ray: I hereby authorize the performance of diagnostic x-rays. The Doctor has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: _____

Adult Female:

Females: Regarding Possibility of Pregnancy This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: _____ Date: _____

Minor:

Consent To X-Ray A Minor I am a parent or legal guardian of _____, who is a minor, _____years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The Doctor has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: _____

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Our "No-Risk, No-Obligation" Consultation

We are one of less than 50 healthcare clinics nationwide licensed to offer *The Advanced Arthritis Relief Protocol*™. The AARP program is a unique approach to the non-surgical treatment of Osteoarthritis of the Knee & Shoulder. By combining a healthcare team consisting of Medical Providers, Physical Therapists, and others we are able to gain a collaborative approach to your care. Utilizing a variety of state-of-the-art medical devices such as digital x-ray, video fluoroscopy, custom engineered knee unloading braces, and more we are able to leverage the latest medical devices to assist in your treatment and care. At Joint Restoration Center we strive to help our patients avoid surgery and regain their optimum function and quality of life.

Because of the unique nature of our facility and our treatment programs we offer a "No-Cost, No-Obligation" Consultation in which you can learn more about us, and we can better understand your condition and healthcare goals. Your consultation today will consist of:

- An explanation of our unique treatment protocol
- The ability for you to ask questions about your health-related issues
- Tour of our facility
- A general opinion as to the ability of the services provided at this facility to possibly help you with your healthcare needs

Once you have received the above and we feel you are a candidate for our unique approach to your healthcare needs, the "No-Cost, No-Obligation" Consultation has ended. In order for you to become a patient and receive care at our facility, a full examination by the treating clinician will be performed. The full exam and any treatment you may have at that time, including x-ray or other diagnostic tests as deemed necessary by the clinician will be billed to your insurance company.

By signing below, you are acknowledging that you have received the "No-Cost, No-Obligation" Consultation and have expressed the desire to become a patient and understand the examination, treatment, and any diagnostics rendered at this point on this day, will be billed to your insurance company.

_____ _____

Patient Signature Date

Notice of Patient Information Policies

This notice describes how medical and personal information about you may be used or disclosed and how you can obtain access to the information. Please review this form carefully.

Our Legal Duty Joint Restoration Center, LLC, is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

Uses and Protocols of Patient Information Joint Restoration Center, LLC, uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to produce. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide to you. In addition, we may, from time to time, disclose information without prior authorization for public health purposes, auditing, racking, and research studies. In any situation, Joint Restoration Center, LLC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease further disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Patient Information Policies will be posted in the same area for public view. You may request a copy of our Notice of Patient Information Policies at any time. Our HIPAA Compliance Officer is Kristi Plunk. She can be reached by calling 817-786-8058.

Patient's Individual Rights You have the right to review or obtain a copy or your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal information for reasons other than that of treatment, payment, or other related administrative purposes. You may request in writing that we not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by the law, or in an emergency. Joint Restoration Center, LLC will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

Concerns and Complaints If you are concerned that Joint Restoration Center, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Kristi Plunk, at the office address and the phone number listed below. You may also send a written complaint to the Us Department of Health and Human Services.

By signing below, you are acknowledging that you have received the "Notice of Patient Information Policies" and a copy of the "HIPAA Privacy Notice".

Patient Signature

Date

JOINT RESTORATION CENTER

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to **Joint Restoration Center** for medical supplies and/or medication(s) furnished to me by **Joint Restoration Center.**

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. **Joint Restoration Center** to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. **Joint Restoration Center** to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )

SIGN YOUR NAME HERE | TODAY'S DATE / /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to **Joint Restoration Center** for any medical supplies and/or medications furnished to me by **Joint Restoration Center**. I authorize any holder of medical information about me to release to **Joint Restoration Center**, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

YOUR MEDICARE # ☐☐☐-☐☐-☐☐☐☐-☐

Insurer_____ **Policy #**_____
(other than or in addition to Medicare)

Insurer Phone # ( )_____

Please correct any errors in your name and address below.

JOINT RESTORATION CENTER

Cancellation Policy

To reach your goals, it is important for you to attend your scheduled treatment sessions. When you schedule, we block the provider's time for a session with you.

A cancellation fee of **$40.00** will be charged for each appointment that is cancelled with less than 24-hour notice. This fee is waived if you make up the visit, within the same calendar week.

If you have more than 3 missed visits that are not made up, even if more than 24-hour notice is given, you will be discharged from physical therapy.

Cancellations impact 3 individuals:

1) Yourself – You limit your ability to reach your goals

2) Your Provider – Time has been made in the provider's schedule specifically for you

3) Another patient – We are unable to fill your appointment slot with others that are needing to get on the schedule when short notice is given.

I agree to a 40.00 cancellation fee to be charged to my credit card on file if less than 24 hours' notice is given for my scheduled appointment.

We are happy to work with your schedule and *the fee is waived when you reschedule your appointment in the same calendar week.*

Patient Signature

Date

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Patient Consent

Please initial next to each patient consent statement.

_____ If prescribed, I hereby consent to physical therapy treatment as prescribed by my provider, or as deemed necessary by the treating physical therapist. I also understand that physical therapy treatment, by its nature, involves inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego physical therapy all together.

_____ I understand I am responsible for charges incurred, regardless of insurance coverage. If Joint Restoration Center, LLC has a contract with your insurance carrier, we will file the claim. If the insurance company denies payment for no referral, non-covered services, deductible, etc., I am responsible for all balances due.

_____ I assign all benefits to Joint Restoration Center, LLC that are received from my insurance provider for physical therapy services rendered.

_____ It is advised that a parent or guardian attend all sessions with patients that are **minors** and I waive any claim that I may have due to my failure to comply with this advisement.

_____ I understand that Joint Restoration Center LLC takes all actions available to keep my personal information private. I have received the Notice of Privacy Practices from Joint Restoration Center, LLC.

_____ _____

Patient Signature Date