ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER
PATIENT REGISTRATION FORM

1. PATIENT INFORMATION **Today's Date**_____

Name_____ Social Security No: _____

Address_____ Date of Birth_____

City_____ State_____ ZIP Code_____ Home Phone_____

Work Phone_____ May we call you at work? Yes ☐ No ☐ Employer _____

Maiden/Former Name_____ Sex_____ Age_____ Email Address_____

Marital Status_____ Race _____ Ethnicity _____

Primary Care Physician_____

Referred to us by_____

Spouse or Parent Name_____ Spouse or Parent Home Phone_____

Employer _____ Work Phone _____

Do you make your own healthcare decisions? Yes ☐ No ☐

If no, who is your POA? _____

Relationship _____ **Telephone Number** _____

2. INSURANCE COVERAGE INFORMATION

ALL patients must answer →

Are you being seen for a work-related injury/condition? _____Y _____N

At this time, I, _____, represent and warrant that I
(Print Your Name)
(DO) or (DO NOT) have **Medicaid coverage.**

Circle One – *If unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot* ***circle one****, please inform the staff immediately if you have Medicaid health insurance coverage.)*

Primary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification #_____

Group #_____ Copay_____

Secondary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification # _____

Group #_____ Copay_____

Tertiary

Insurance Carrier _____

Employer_____

Insured's Name (Policyholder)_____

Relationship to Patient_____ Birth Date_____

Social Security #_____

Subscriber Identification #_____

Group #_____ Copay_____

Workers Comp

Insurance Carrier _____

Employer_____

Claim # _____

Date of Injury_____

Body Part _____

3. ASSIGNMENT AND RELEASE OF INFORMATION

MEDICARE: I request that payment of authorized Medicare benefits be made to Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian_____Date_____

ALL PATIENTS: I hereby authorize the offices of Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau (OAW/PRO), to release any medical information required during the course of examination and treatment to my insurance company(ies), and I permit payment to OAW/PRO from my insurance for any benefits due for their services rendered. I permit a photographic or other facsimile of this authorization to be used in place of the original. **I agree to pay those charges which may not be paid by my health insurance and are my responsibility per insurance benefits.**

Patient/Guardian_____Date_____

4. PRESCRIPTION HISTORY

I agree that OAW/PRO may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Patient/Guardian_____Date_____

5. PATIENT COMMUNICAITONS

I authorize OAW/PRO to contact me at the phone number(s) and e-mail address I provided during my registration as a patient. OAW/PRO may contact me via phone call, text message, or e-mail. The messages may be automated, autodialed, prerecorded calls and/or texts to communicate appointment reminders, notifications regarding the availability of path or lab results, billing and collection information, and marketing or advertising messages offering products or services that may be of interest to me. I understand that I am not required to give the consent as a condition of receiving medical care or goods. I may revoke my consent to receiving such calls and/or messages at any time by contacting OAW/PRO in writing, by phone, or by following the automated prompts provided in those messages.

Patient/Guardian_____Date_____

6. PRIVACY

I acknowledge I have been provided or offered a copy of the Privacy Practices of Orthopaedic Associates of Wausau/PRO Physical Therapy and Hand Center (OAW/PRO). These can also be accessed on our website at oaw-ortho.com.

Patient/Guardian_____Date_____

DISCLOSURE/DISCLAIMER OF OWNERSHIP

PRO Physical Therapy & Hand Center of Wausau is a division of Orthopaedic Associates of Wausau, and is fully owned and operated as part of their comprehensive services that they deliver for their patients. As an OAW patient, there is no obligation for you to receive physical therapy and occupational therapy services at our clinic, and as always, you have the right to choose any rehab provider or location that you desire.

Orthopaedic Associates of Wausau and PRO PT complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

We accept cash, check, VISA MasterCard DISCOVER and offer CareCredit (www.carecredit.com

OAW/PRO Respect Policy

At Orthopaedic Associates of Wausau and PRO Physical Therapy and Hand Center (OAW/PRO), we are committed to taking care of you. We have trained staff members to assist you with your entire experience at our clinics.

Because we know our staff work hard and care about patients, we expect all guests (patients or those accompanying a patient) of our clinic to treat our staff respectfully. Foul language or intimidating or abusive behavior will not be tolerated, in person or via telephone.

Please be aware that, should you act in a manner that is threatening, abusive or disrespectful to our staff, it will be considered grounds for dismissal from OAW/PRO.

I understand and acknowledge this policy.

_____ _____

Signature Date

Patient Financial Policy

Thank you for choosing Orthopaedic Associates of Wausau and/or PRO Physical Therapy and Hand Center! We are committed to providing you high quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

General Insurance Info

- It is your responsibility to provide us with complete and accurate insurance coverage information, as we bill your insurance as a courtesy to you
- If accurate and complete information isn't provided before or at the time of service, you are responsible for the full balance
- If your insurance company requires a referral and/or preauthorization to come to our clinic, you are responsible for obtaining it
- If your insurance requires a copay, we will collect that copay at the time of service
- It is your responsibility to understand your insurance benefits, however, we are happy to help you with this
- Certain procedures will not be performed until insurance coverage has been verified, our office will work with you on this.
- If you are covered under an insurance contract, we are unable to provide additional discounts
- If you are not able to pay your balance in full, we offer payment arrangements

Self-Pay Accounts

- Patients without insurance coverage or patients with third party liability coverage
- A down payment will be required at the time of scheduling and will be applied to charges related to your visit
    - **OAW:** $350 down payment at initial visit
    - **PRO:** $150 down payment at initial visit and $100 at subsequent visits
- You may be eligible for a discount, please contact our office for additional information
- If you are not able to pay your balance in full, we offer payment arrangements
- We do not participate in community care programs utilized by local hospitals

Workers' Compensation

- It is your responsibility to contact your employer/human resources department to report your injury
- To file a claim on your behalf, we require a claim number, phone number, contact person and name and address of the workers' compensation insurance carrier
- If this information is not provided, we will bill your primary health insurance. If you do not have health insurance, you will be responsible for the balance

Minors

- The parent or guardian is responsible for full payment and will receive the billing statement
- **For divorced/separated parents, the parent presenting with the dependent is responsible for all charges. If the divorced decree indicates otherwise, the responsible parent must sign the financial policy and assignment of benefits on the patient registration form.**

Surgeries and Other Services

- A partial payment prior to services may be required for higher cost procedures, our insurance department will work with you on this

Collection Accounts

- If we are unable to work with you to pay your balance and your payments default, we may turn your account over to a collection agency

Non-Sufficient Funds (NSF)

- Check Policy – By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, your account will be charged back the face value of the check plus the amount any applicable fees as permitted by state law

If you have any questions or need clarification of any of the above policies, please contact our insurance department Monday through Friday, 8:00 am to 5:00 pm at 715-907-0900.

I acknowledge that I have read, understand and accept the about Financial Policy:

_____ _____

Patient/Guarantor Signature **Date**

ORTHOPAEDIC ASSOCIATES OF WAUSAU

PRO PHYSICAL THERAPY & HAND CENTER
Performance. Rehabilitation. Orthopaedics.

OAW Prescription Refill Policy

It is the policy of Orthopaedic Associates of Wausau to refill medications, including narcotic pain medication(s), during regular business office hours only.

Please be aware that telephone calls to the office for refill requests can take up to 24 hours to process.

Please remember to ask for any medication refills at your office appointment.

I understand and acknowledge this policy:

_____ _____

Name Date

ORTHOPAEDIC ASSOCIATES OF WAUSAU

PRO PHYSICAL THERAPY & HAND CENTER
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DISCLOSURE OF RECORDS

This form is intended to identify those individuals (family members, close friends, or other persons) to whom we can disclose your protected health information or notify them regarding your care. This form will remain in force until you provide us with written notice otherwise.

☐ **I am the only person who is to have access to my medical and billing information.**

Emergency Contact:

Name _____

Address _____

Telephone _____ Relationship _____

☐ Emergency Contact Only ☐ May Disclose Medical and Billing Information ☐ May Disclose Medical Information Only

Other Contacts for Disclosure of Records:

1. Name _____ ☐ Medical and Billing

Address _____ ☐ Medical Only

Telephone _____ Relationship _____

2. Name _____ ☐ Medical and Billing

Address _____ ☐ Medical Only

Telephone _____ Relationship _____

I agree that protected health information regarding my care and/or treatment may be disclosed to the above-named individuals. This Authorization will remain in effect until I provide written notice to change it.

Signed _____ Date _____

If this form is being signed by a **Patient's Authorized Representative**, please complete the following:

Representative's Name _____

Relationship to patient and reason for signing: _____

ORTHOPAEDIC ASSOCIATES OF WAUSAU PATIENT HEALTH HISTORY FORM

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Full Name: _____ Gender: _____ Date of Birth: _____

Do you have an Advanced Directive? Yes ☐ No ☐ If no, would you like information on how to get one set up? Yes ☐ No ☐

Medication List: *List prescribed medications, vitamins, herbal, inhalers, and/ or diet supplements.*

Medication	Dosage	Reason for taking this medication

Allergies:

Type	Reaction

Do you have any of the following:

Allergy to any of the following?		
Adhesive Tape	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Contrast Dye	☐ No	☐ Yes
Metal	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Family history of Malignant Hyperthermia	☐ No	☐ Yes

Implanted devices:_____
Prosthesis (type): _____
Hearing aid (R/L): _____
Dentures/ Partial (upper/lower): _____
Glasses/ contacts (R/L): _____

Do you have any history of:

- ☐ High Blood Pressure
- ☐ Frequent Headaches
- ☐ Ulcer
- ☐ GERD
- ☐ Stomach Pain
- ☐ Diabetes, type _____
- ☐ Mental Illness
- ☐ Spinal Cord injury
- ☐ Blood Clots
- ☐ HIV/ AIDS
- ☐ Jaundice/ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Attack
- ☐ ADHD
- ☐ Angina
- ☐ Heart Murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/ Epilepsy
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Paralysis
- ☐ Eczema/ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ Anxiety
- ☐ Depression
- ☐ COPD
- ☐ Arthritis, type_____
- ☐ Cancer, type _____
- ☐ Excessive Bleeding
- ☐ High Cholesterol/ Lipids
- ☐ Blood Transfusion
- ☐ Thyroid Disease
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Numbness, location _____
- ☐ Tingling, location_____
- ☐ Other _____

If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected. _____

_____

Surgeries:

Procedure	Hospital	Date

Family Health History:
Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Gender	Significant Health Problems		Age	Gender	Significant Health Problems
Father				Child		☐ M ☐ F	
Mother				Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Child		☐ M ☐ F	
Sibling		☐ M ☐ F		Grandparents		☐ M ☐ F	

Bone Health: *Check any of the below that you have had.*

☐ Fracture from a fall or low impact injury
☐ Fracture of the wrist, spine or hip
☐ Vitamin D Deficiency
☐ Frequent falls
☐ Long term use of steroids (Name of steroid and what you took it for)
_____
☐ Had a Bone Mineral Density Test (DXA Scan). If yes, when and where?
_____
☐ Had treatment for Osteoporosis. If yes, what and when?
_____

Social History:

☐ Work in the home?	☐ Employed (occupation_____)		☐ Student	☐ Daycare	☐ Retired
☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed	
Children? ☐ No	☐ Yes	How many? _____			
Do you live alone? ☐ No	☐ Yes				
Exercise? ☐ Daily	☐ Weekly	☐ Monthly	☐ Rarely	☐ Never	
What type of exercise? _____					
History of substance abuse? ☐ No	☐ Yes	What? _____			
Have you ever been or are you currently on a pain contract? ☐ No	☐ Yes	With Whom? _____			
Current Tobacco User? ☐ No	**Type:** ☐ Cigarettes: Packs/quantity per day _____		☐ E-Cig/Vape	☐ Smokeless Tobacco	
Quit smoking? ☐ This year	☐ Less than a year	☐ Less than five years	☐ Less than 10 years		
Previously smoked _____ packs per day for _____ years.					
Drink alcohol? ☐ No	☐ Daily	☐ 1-2 times a week	☐ 1-2 times per month	☐ 1-2 times per year	

***** ONLY COMPLETE IF YOU ARE HERE FOR PRO PHYISCAL THERAPY: *****

Reason for attending therapy? _____

- If for upper body injury, are you ☐ Right ☐ Left-Handed

Date symptoms occurred: _____ Cause of your injury: _____

What makes your symptoms worse: _____

What makes your symptoms better (please circle): Ice Heat Meds Rest Activity Massage Other: _____

Main Goal(s) for Therapy: _____

Have you ever had treatment for this problem before: ☐ Yes ☐ No

- If Yes, what kind of treatment have you had (please circle): PT OT Chiropractic Massage Therapy Other: _____

What is your preferred learning style(s) (please circle): visual/seeing auditory/hearing tactile/doing (performance)

Is this Worker's Compensation: ☐ Yes ☐ No

- If yes, do you have work restrictions? ☐ Yes ☐ No If yes, what are they: _____
- How many hours a week do you normally work? _____
- Have you returned to work? ☐ Yes ☐ No
  - If yes, at what capacity? How many hours per week are you currently working? _____
  - Are you performing your normal work duties? ☐ Yes ☐ No If No, please explain: _____

Patient Signature: _____ Date: _____