ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER
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.

Social Security Number (SSN):_____ Appointment Date_____

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

Non-Medication Allergies:

Are you allergic 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

Do you have any of the following?

Implanted devices:_____
Prosthesis (type): _____
Hearing aid (R/L): _____
Dentures/ Partial (upper/lower): _____
Glasses/ contacts (R/L): _____
If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected.
_____

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
- ☐ Angina
- ☐ Heart Murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/ Epilepsy
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Paralysis
- ☐ Eczema/ Psoriasis
- ☐ Raynaud's Syndrome
- ☐ ADHD
- ☐ Depression
- ☐ Arthritis, type_____
- ☐ Cancer, type _____
- ☐ Excessive Bleeding
- ☐ High Cholesterol/ Lipids
- ☐ Blood Transfusion
- ☐ Thyroid Disease
- ☐ Sickle Cell Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Other_____

Surgeries:

Procedure	Hospital	Date

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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? _____

Smoke currently? ☐ No ☐ Yes **Type:** ☐ Cigarette ☐ Vaping ☐ Chew ☐ Other: _____ Packs/quantity per day ___ for____ years.

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? ☐ Daily ☐ 1-2 times a week ☐ 1-2 times per month 1-2 times per year

Review of Systems:
Mark yes or no and CHECK any of the following you have recently had:

Constitutional Symptoms ☐ No ☐ Yes
☐ Fatigue ☐ Fever ☐ General aching ☐ Night sweats
☐ Unintentional weight gain ☐ Unintentional weight loss

Eye Problems ☐ No ☐ Yes
☐ Blurred vision ☐ Red eye ☐ Sensitivity to light

Cardiovascular Problems ☐ No ☐ Yes
☐ Blacking out or fainting ☐ Chest pain
☐ Irregular heart beat

Respiratory Problems ☐ No ☐ Yes
☐ Frequent productive cough Shortness of breath
☐ Wheezing

Abdominal Pain ☐ No ☐ Yes
☐ Change in bowel habits ☐ Nausea ☐ Vomiting

Neurologic Problems ☐ No ☐ Yes
☐ Difficulty walking ☐ Numbness ☐ Tingling

Psychiatric Problems ☐ No ☐ Yes
☐ Feels nervous (anxiety) ☐ Feels sad (depression)
☐ Trouble sleeping

Endocrine Problems ☐ No ☐ Yes
☐ Feels cold

Hematologic/ Lymphatic Problems ☐ No ☐ Yes
☐ Bruises easily

Allergic, Infectious, Immunologic ☐ No ☐ Yes
☐ Infections recurring

Patient Signature: _____ Date: _____

TO ALL FEMALE PATIENTS: For your safety, if you are pregnant or think you may be pregnant, inform the doctor prior to your x-ray examination.

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

Received HIPAA Info Today (initial please) _____ Race _____ Ethnicity _____

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

Name_____ Social Security No: _____

Address_____ Email Address_____

City_____ State_____ ZIP Code_____

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

Maiden/Former Name_____ Employer _____

Sex_____ Age_____ Date of Birth_____ Marital Status_____

Primary Care Physician_____

Referred to us by_____

Spouse or Parent Name_____ Employer _____

Spouse or Parent Home Phone _____ Work Phone _____

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

If no, who is your POA? _____

Relationship _____ **Telephone Number** _____

2. INSURANCE COVERAGE INFORMATION **Work Related Injury?** _____Y _____N

Primary	**Secondary**
Name of Health Insurance_____	Name of Health Insurance_____
Employer_____	Employer_____
Insured's Name (Policyholder)_____	Insured's Name (Policyholder)_____
Relationship to Patient_____ Birth Date_____	Relationship to Patient_____ Birth Date_____
Social Security #_____	Social Security #_____
Subscriber Identification #_____	Subscriber Identification #_____
Group #_____ Copay_____	Group #_____ Copay_____

3. ASSIGNMENT AND RELEASE OF INFORMATION/ MEDICARE SIGNATURE ON FILE

I hereby assign Orthopaedic Associates of Wausau, and PRO Physical Therapy & Hand Center of Wausau to receive payment of authorization **MEDICARE** benefits on my behalf for medical, surgical services and/or therapy.

Patient/Guardian_____Date_____

I hereby **assign the benefits from my Insurance Carrier(s) to Orthopaedic Associates of Wausau, and/or PRO Physical Therapy & Hand Center of Wausau** for the medical, surgical and/or therapy benefits I am entitled.

I authorize the release of information to Orthopaedic Associates of Wausau, PRO Physical Therapy & Hand Center of Wausau, the Health Care Financing Administration, the Organized Health Care Arrangements that OAW and PRO PT is part of, and its agents for any provider relating to medical care. I authorize release of medical information required to act on claims to carriers listed above. 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 Orthopaedic Associates of Wausau 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_____

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.

ORTHOPAEDIC ASSOCIATES OF WAUSAU

PRO PHYSICAL THERAPY & HAND CENTER
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Patient Financial Policy

Thank you for choosing Orthopaedic Associates and/or PRO Physical Therapy & Hand Center of Wausau as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient financial policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Co-Pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. No post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us (out of network), you agree to pay any portion of the charges not covered by insurance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. For questions regarding deductibles, co-payments, coinsurance, non-covered services, and referral requirements please contact your insurance company.

Referrals and Preauthorization

If your insurance company requires a referral and/or preauthorization to come to our clinic, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and the balance will be your responsibility. As a courtesy to our patients, we will obtain prior authorization for any services that our office orders.

Auto Insurance/Third Party Liability

All liability/motor vehicle cases will be filed with your health carrier unless your primary carrier is Medicare, where we are required by law to file with the liability/motor vehicle insurance. We will assist you in supplying you with copies of your billing or claim forms for submission to a liability/motor vehicle carrier. Ultimately, payment for your medical care is your responsibility. We do not accept attorney letters or contingency payments.

Cancellation

Patient will not be charged if they cannot make the appointment, but please provide us with at least a 24-hour notice so we can fill the time slot.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, or patients without an insurance card on file with us. Liability/motor vehicle cases will also be considered self-pay accounts. It is always the patient's responsibility to know if our office is participating with their plan.

> ***Orthopaedic Associates:*** Patients will be required to bring $350 at the time of the initial appointment. You will be asked to make payment arrangements for the balance. You will be asked to pay for charges on the day of service in full and if you are able to, a discount will be applied to your total fee. If you are having surgery, you will be expected to pay a deposit of one half of your remaining patient responsibility before services are rendered.
>
> ***Pro Physical Therapy:*** Patients will be required to bring $150 at the time of the initial appointment and $100 to subsequent appointments.

Orthopaedic Associates is an independent, private practice and does not participate in the Community Care Program utilized by local hospitals. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients.

Workers' Compensation

In the case of a workers' compensation injury, it is your responsibility to contact your employer/human resource department, prior to being seen. Please provide us with a claim number, phone number, contact person, and name/address of the insurance carrier prior to your visit. If this information is not provided, you will be asked for payment at the time of your service. We require that you provide us with your private health insurance should your claim be denied or your benefits are exhausted.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statement for any patient under the age of 18. A signed release to treat may be required for unaccompanied minors. If you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Outstanding Balance Policy

It is our policy that all accounts are paid in a timely manner after receipt of statement. If payment in full is not received, or a mutually agreed upon payment plan made within 30 (thirty) days, collection action may commence. Monthly payments that are missed may also be subject for immediate collection action. In the event an account is turned over for collection, any further communication will need to be directed to the collection agency.

This financial policy helps our office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please do not hesitate to contact us Monday through Friday 8:00 a.m. to 5:00 p.m. at 715-847-2382.

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

_____ _____

Patient/Guarantor Signature **Date**

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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.

Emergency Contact:

Name _____

Address _____

Telephone _____ Relationship _____

☐ Emergency Contact Only ☐ May Disclose Protected Health Information

Other Contacts for Disclosure of Records:

1. Name _____

Address _____

Telephone _____ Relationship _____

2. Name _____

Address _____

Telephone _____ Relationship _____

3. Name _____

Address _____

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: _____

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OAW Narcotic Refill Policy

It is the policy of Orthopaedic Associates of Wausau to refill narcotic (pain medication) only during regular business office hours (Monday – Friday, 8 am – 5 pm). Telephone calls to the office Triage Nurse for refill requests can take up to 24 hours to process.

Please remember to ask for any medication refills at your office appointment. **Refill requests called in after regular business hours WILL NOT be filled by the on-call physician.**

I understand and acknowledge this policy:

_____ _____

Name Date

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PRO PHYSICAL THERAPY & HAND CENTER
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OAW/PRO Respect Policy

At Orthopaedic Associates of Wausau and PRO Physical Therapy and Hand Center, 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 Orthopaedic Associates of Wausau and PRO Physical Therapy and Hand Center.

I understand and acknowledge this policy.

_____ _____

Signature Date