POTOMAC VALLEY ORTHOPAEDIC ASSOCIATES
The Centers for Advanced Orthopaedics

PATIENT INFORMATION (Please Print)

Office Use Only Patient Account # _____ Employee Initials _____

Patient's Name (Last, First, Middle Initial) _____
Responsible Party (if minor) _____
Address _____ City _____ State _____ Zip _____
Home Phone No. ( )_____ Business Phone No. ( ) _____
Cellular Phone No. ( )_____ Email Address _____
Date of Birth _____ Age _____ Sex: M ☐ F ☐ Social Security No. _____
Employed: Y ☐ N ☐ Occupation _____ Full Time Student: Y ☐ N ☐
Patient's / Parent's Employer _____
Emergency Contact & Relationship:_____/_____ Phone No. ( ) _____
Primary Care Physician: _____ Phone No. ( ) _____
Referring Physician: _____ Phone No. ( ) _____
Pharmacy Name: _____ Phone No. ( ) _____
Language:_____ Race:_____ Ethnicity:_____

I would like to complete the Confidential Communication form allowing a family member/specific individual(s) access to my protected health information: Y ☐ N ☐

PRIMARY INSURANCE COMPANY _____
Policy/ID No. _____ Group No. _____ Effective Date _____
Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____
Policy Holder's Employer _____

SECONDARY INSURANCE COMPANY _____
Policy/ID No. _____ Group No. _____ Effective Date _____
Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____
Policy Holder's Employer _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION (Please Read and Sign Below)

By signing below, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I hereby give my consent for Potomac Valley Orthopaedic Associates and Sports Medicine & Rehabilitation Center a division of The Centers for Advanced Orthopaedics to furnish information to insurance carriers concerning my physical condition and treatments, and I hereby assign to the Physicians all payments for Medical Services rendered to myself or my dependents.
I understand that I am responsible for all fees and finance charges for the above named patient, regardless of Insurance coverage. If, after default, this account is placed in the hands of a collection agency, the undersigned agrees to pay 30% of the unpaid balance as a reasonable collector's fee, together with the additional costs and expenses of collection to the extent permitted by law.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES (Please Read and Sign Below)

By signing below, you acknowledge the availability of our Notice of Privacy Practices pamphlet, which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to change the terms described, and should we do this we will post the changes in all of our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. **OSHA**: The state of Maryland requires that a patient be tested in the event of a health care exposure, by signing the patient is agreeing to be tested.
** Please Note: Exposure testing will include rapid HIV, rapid Hepatitis C antibody, and Hepatitis B surface antigen. In accordance with Maryland law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.**

Signature _____ **Date** _____

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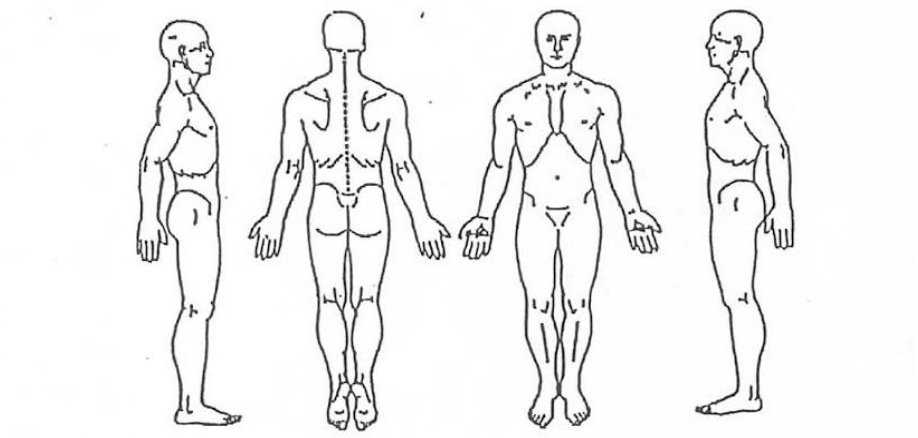
Name: _____ **Age**: _____ **Date**: _____
Body Part: _____ **Date of Injury**: _____ **Date of Surgery**: _____
Occupation: _____
Work Status: □ Regular □ Light Duty □ Not working due to this problem □ Retired □ Other
Mark on picture where you have symptoms:



Type of Pain: □ Sharp □ Dull □ Burning □ Tingling □ Numbness
□ Stiffness □ Aching □ Swelling □Throbbing □ Other
The pain is: □ Constant □ Intermittent (comes and goes)
What make symptoms better? _____
What make symptoms worse? _____

Please rate the following on a scale of 0-10 (0= no pain, 10= the worst pain imaginable)
1. Your current pain level: ____ out of 10
2. The least pain that you've had in the past week: ____ out of 10
3. The most pain that you've had in the past week: ____ out of 10

Have you had ever had Physical Therapy in any facility, including home health PT, for any body part within the past year? YES or NO
If yes, how many visits?_____ Name of Facility:_____

Medical History - Please check any boxes that apply:

Heart Problems		Epilepsy	
Pacemaker		Kidney Problems	
Heart Attack		TMJ	
High/ Low Blood Pressure		Arthritis	
Cancer		Headaches	
Diabetes		Dizziness	
Osteoporosis		Hypoglycemia	
Asthma		Difficulty Swallowing	
Lung Disease		Latex Allergy	
Back or Neck Problems		Alcohol/ Drug Problems	
Have you ever been pregnant?		Smoking	
Are you currently pregnant?		Other	

Other Medical History: _____
Major Surgeries: _____
_____
Please list (or attach) all medications that you are currently taking: _____
_____
Emergency Contact: _____ **Number**: _____

Patient's Informed Consent

I, _____, the undersigned, acknowledge that I have agreed to participate in the plan of care for the treatment of the condition for which I was referred by my physician to restore acceptable levels of functional ability.

I understand that the treatment may consist of a variety of therapeutic procedures including, but not limited to, manual therapy, therapeutic exercises (including progressive resistance exercise and aerobic activity), electrical stimulation, ultrasound, muscle testing, functional activities, traction, vasopneumatic devices, and others forms of intervention appropriate for my condition.

I also understand that I have the right to discontinue and/or refuse treatment at any given time. I will not hold the licensed and support staff of Potomac Valley Sports Medicine, a Division of The Centers for Advanced Orthopaedics, liable in the event I discontinue and/or refuse care during the course of my treatment plan.

As of November 17th 2003, I am aware of and agree to the **Cancellation and No Show Policy**, which states all appointments must be cancelled at least 2 hours prior to your appointment time or a $25.00 fee will be issued.

In light of this information, I agree to be treated and supervised by the licensed and support staff of Potomac Valley Sports Medicine.

_____ ___/___/___

Patient's Signature

_____ ___/___/___

Parent or Legal Guardian if under 18