



**Rehabilitation Directors**  
Joseph Distel, PT Ext. 238  
Larry Adolph, PT Ext. 239

## **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.

General phone number: 419-427-1984

Scheduling: Ext. 222

### **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:	State:	Zip:
Home Telephone:	Cell Phone:	Other Phone:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
If Medicare, are you currently residing in a Skilled Nursing Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility _____			
If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, do you know if you have exceeded the Medicare cap? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Medicare, are you currently receiving Home Health Services: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		City/State of Referring Physician:

### Employer Information

Employer:	Employer Phone:	Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> None
Address:	City:	State: Zip:

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

If Minor, Does child live with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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:
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### 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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.

Grid of checkboxes for body parts: Neck, Arm, Knee, Shoulder, Wrist, Foot, Elbow, Back, Ankle, Pelvis, Finger, Hand, Hip, Toe. Includes RT/LT and T/B (2-5) options.

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.

Sections for injury types: No Injury, Injury, Injury at Work, Work Related, but NO Injury, Auto Accident. Includes 'Answer/Comment' column with lines for notes.

\*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

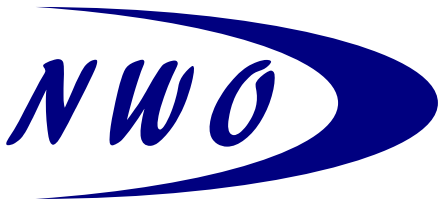
Do you use Tobacco?  Y  N Packs/ day \_\_\_\_\_ Alcohol?  Y  N How often?  Daily  \_\_\_\_\_/week

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, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO is not in your insurance plan, the patient/guarantor 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 No-Show Fee:**

Missed or non-cancelled appointments may result in a service fee.

### **Imaging No-Show Fee:**

Cancellation within 24 hours prior to a scheduled MRI or a scheduled 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.

### **Medical Records Copying Fees:**

Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: \$2.84/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Fees for a non-personal representative are: \$17.48 retrieval fee, \$1.15/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Film prices for patient/representative and non-representative are: \$1.94/sheet or \$1.00/disc. Postage paid to send records will also be paid by the requestor.

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**Patient/Guarantor Signature**

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**Date**

