CAPE COD ORTHOPAEDICS & SPORTS MEDICINE P.C.
CAPE COD ORTHOPAEDICS PHYSICAL THERAPY
CAPE & ISLANDS OCCUPATIONAL MEDICINE

Patient Information (Please Print)

Last Name: _____ First Name: _____

Middle Initial: _____ Gender: _____ Marital Status: _____ Birth Date: _____

Student: Y/N Veteran: Y/N Email address: _____

Would you like to sign up for the Patient Portal? Yes _____ No _____ Ask the front desk staff how!!!!!

PO Box/Mailing: _____ City: _____ State: _____ ZIP: _____

Current address: _____ City: _____State: _____ Zip: _____

Out of State address: _____City: _____ State: _____ Zip: _____

Home Phone (___) _____ Cell Phone (___) _____

Primary Employer: _____ Work number: (___) _____

Emergency Contact: _____ Relationship: _____ Phone: (___) _____

Primary Care Physician: _____

Who referred you to Cape Cod Orthopaedics? _____

Primary Insurance name: _____ Policy Number: _____

Secondary Insurance name: _____ Policy Number: _____

Was your injury due to: Motor Vehicle Accident Y/N Work related Accident Y/N

NOTICE OF AUTHORIZATION AND CONSENT TO TREAT

I hereby authorize Cape Cod Orthopedics and Sports Medicine, P.C. and its entities/affiliates/agents to evaluate and treat my condition and my examination findings as medically necessary. Treatment that I consent to, may include, but not limited to; therapeutic strengthening, functional simulation, neuromuscular re-education, manual therapy including manipulation and mobilization, physical therapy/occupational therapy modalities including dry needling, gait and balance training, and vestibular/sensory treatment, as medically intended.

Signature of Patient (or Guardian) _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT PATIENT CONSENT FORM

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that is information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you are "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Cape Cod Orthopaedics & Sports Medicine, P.C. has the right to change its "Notice of Privacy Practices" from time to time and that I may contact Cape Cod Orthopaedics & Sports Medicine, P.C. at 508-775-8282 or by mail at 130 North Street, Hyannis, MA 02601 any time to obtain a current copy of the "Notice of Private Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

I also authorize this practice to disclose my medical information

To my Primary Care Physician: (name) _____ Yes _____ No _____

On my answering machine/voicemail: Yes _____ No _____

To my spouse: If yes Name _____ No _____

To my adult children, additional family and or friend(s): if yes Name(s) _____

_____No _____

_____ _____

Signature of **Patient** (or Guardian / Personal Representative) Date

Print Patient's Name: _____

CAPE COD ORTHOPAEDICS & SPORTS MEDICINE P.C.

By signing below, I hereby acknowledge I have read and understand the entirety of this document.

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS *(Medicare Patients Only)*

I request payment of authorized Medicare benefits be paid on my behalf to Cape Cod Orthopaedics and Sports Medicine, P.C. for any services furnished by their physicians and providers. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits, or the benefit payable for related services.

In order to get Medicare payments and benefits we may need your **SSN#** _____

Signature of Patient or Guardian _____Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY (*Must be 18 years of age)*

I authorize Cape Cod Orthopaedics & Sports Medicine P.C. to release any information required in the course of this examination and my treatment to my insurance company, primary care physician or other third party as requested by me. I also authorize and direct payment of all medical/surgical benefits directly to Cape Cod Orthopaedics & Sports Medicine, P.C. I understand my Insurance and/or Medicare may not cover all charges and agree to accept responsibility for payment of those charges.

Signature of Patient or Guardian _____Date: _____

NO SHOW/CANCELLATION POLICY ACKNOWLEDGEMENT

I understand there is a **$75.00 No Show/Cancellation Fee** if I fail to cancel any office appointment within 24 hours of the scheduled visit, and a **$250.00 Cancellation Fee** if I fail to cancel any scheduled surgery within 7 days of the date of surgery. A copy of our No Show/Cancellation policy is available upon your request.

Signature of Patient or Guardian _____Date: _____

MEDICAL RECORD/ FMLA REQUEST FEE ACKNOWLEDGEMENT

I understand I will be responsible for **$25** charge for over 101-copied pages of my medical record(s), **$35** charge for completion of FMLA forms that are completed by providers of Cape Cod Orthopaedics & Sports Medicine, P.C. I will be notified of charges and payments to be obtained prior to record completion.

Signature of Patient or Guardian _____Date: _____

DURABLE MEDICAL EQUIPMENT RETURN/RESTOCKING FEE ACKNOWLEDGEMENT

I understand I will be responsible for a **$15.00 Restocking Fee** in the event my durable medical equipment is to be returned and condition has been inspected and approved for return, **within 14 days** of dispense.

Signature of Patient or Guardian _____Date_____

Print Patient's Name: _____

HISTORY OF PRESENT ILLNESS (PLEASE PRINT)

Patient Name_____ Date of birth_____

Body part(s) to be evaluated: _____

Was your injury due to a: ○Motor vehicle accident ○Work related injury ○ Liability ○ Other

If yes, Date of injury_____ Where and how did your injury occur? _____

Have you been treated by a physician for THIS problem? ○No ○Yes Dr. Name_____

Was an MRI and /or X-Ray taken for THIS problem? ○No ○ Yes If Yes, Where _____ When _____

What treatments have you had to date for THIS problem: ○ Physical Therapy ○Splints ○ Medication

○ Surgery ○Exercise ○Injection ○Chiropractor ○Podiatrist

SOCIAL HISTORY

Occupation _____ Education _____

Smoke ○Never ○Yes ○Former **Recreational drugs** ○No ○Yes **Alcohol** ○No ○Yes

Caffeine ○No ○Yes ○ **Lt handed** ○ **Rt handed** **Activity level**: ○Above ○Average ○Sedentary

Height_____ **Weight**_____lbs.

Exercise Frequency_____ **Type of Exercise**_____

CURRENT MEDICATIONS (PLEASE PRINT)	DOSAGE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies: _____ Other Allergies: _____

Preferred Pharmacy: _____
Name Town/Address

SURGERIES (Side if applicable) and YEAR:
_____(_____) _____(_____) _____(_____) _____(_____)

PAST MEDICAL HISTORY & ILLNESS (PLEASE CHECK)

Patient Name_____ Date of birth_____

○ Alcoholism	○ Alzheimer's	○ Anemia	○ Arthritis	○ Asthma	○ Blood Clots
○ Cancer(TYPE)	○ Depression	○ Diabetes	○ Drug Abuse	○ High Cholesterol	○ Hypertension (HighBP)
	○ Heart Disease	○ Hepatitis	○Kidney Disease	○ Osteoarthritis	○ Seizures
○ Ulcers	○ Gout	○	○	○	○

FAMILY MEDICAL HISTORY (PLEASE CHECK)

DISEASE: FAMILY MEMBER(S)

○ CANCER (TYPE) _____ ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ DIABETES ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ HEART DISEASE ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ HYPERTENSION (HIGH BLOOD PRESSURE) ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ OSTEOPOROSIS ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ OSTEOARTHRITIS ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

○ OTHER _____ ○ Mother ○Father ○Sister ○Brother ○Grandmother ○Grandfather
Maternal/Paternal Maternal/Paternal

REVIEW OF SYSTEMS

Please mark if you have any of these symptoms **TODAY**:

CONSTITUTIONAL: ○ Fever ○ Fatigue ○ Night Sweats

HEENT: ○ Vision ○ Headaches

CARDIOVASCULAR: ○Chest Pain ○ Palpitations

RESPIRATORY: ○Cough ○Shortness of Breath

GASTROINTESTINAL: ○ Vomiting ○Diarrhea ○Constipation

GENITOURINARY: ○ Urinary Difficulty ○ Pain ○Blood

SKIN: ○ Rashes ○ Changes Skin ○Changes Hair

NEUROLOGICAL/PSYCHIATRIC: ○Dizziness ○Emotional Disturbances

METABOLIC/ENDOCRINE: ○ Cold Intolerance ○ Heat Intolerance