

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

1. PATIENT INFORMATION

Name _____ Maiden/Former Name _____

Social Security No _____ Date of Birth _____ Employer _____

Email Address _____

Race: White Black or African American Asian Native Hawaiian or Other Pacific Islander American/Alaskan Native Unknown

Ethnicity: Latino/Hispanic Not Hispanic or Latino Other Unknown Marital Status: _____ Gender: _____

Primary Care Physician _____ Facility: _____

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.)

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 COMMUNICATIONS

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. 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.



Please review our office policies regarding financial responsibility and prescription refills. You may view a copy of these policies at our front staff desk, on our website at www.oaw-ortho.com or using the QR code below. You can request a printed copy of these policies from our front staff team.



Please initial each line item below:

_____ I have reviewed the OAW/PRO Financial Policy.

_____ I have reviewed the OAW Prescription Refill Policy.

Please sign and date that you understand and acknowledge these policies.

Patient/Guardian _____

Date _____



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.

Patient Name _____ Date of Birth _____

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
- May Grant Portal Access (includes Medical and Billing)

Other Contacts for Disclosure of Records:

1. Name _____

Address _____

Telephone _____ Relationship _____

- Medical and Billing
- Medical Only
- Portal (included Medical & Billing)

2. Name _____

Address _____

Telephone _____ Relationship _____

- Medical and Billing
- Medical Only
- Portal (included Medical & Billing)

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.

Print Name _____

Signature _____ **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: _____

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		<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				Child		<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling		<input type="checkbox"/> M <input type="checkbox"/> F		Child		<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling		<input type="checkbox"/> M <input type="checkbox"/> F		Grandparents		<input type="checkbox"/> M <input type="checkbox"/> 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:

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

Patient Signature: _____ **Date:** _____



Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- **Better coordinate your care across different doctors** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
 - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- **Support better care decision-making** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
 - This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- **Deliver care more promptly and efficiently** — With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
 - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- **Securely and confidentially** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
 - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

How do I sign up?

It's quick and easy. Show the staff at the front desk or during patient discharge your government-issued ID (driver's license, etc.) and tell them what other doctors, hospitals and healthcare providers you've seen.

Patient Signature _____

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems. The end results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Participating vendors are: Allscripts, athenahealth, Cerner, CPSI, Greenway, McKesson, and Sunquest.