DOB____________

INITIAL EVALUATION

Subjective:

Name:____**Date**____________________**Age:**______________
Physician:_____________________________**Diagnosis:**____
Occupation:_____________________________**Sport/Activity:**_______________________________________
Physical Demands of the job?____

Please circle which body part you are seeking treatment: Left Right
Neck Mid Back Low Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/foot
Other____

Date of injury:_____________ **Date of Surgery:**____________

What caused your injury or problem?____
____

What is your chief complaint?____

Have you had similar occurrences in the past?____
____

Have you had previous treatment? What kind?____________________________________ **When:**_______

Circle recent tests- MRI Xrays CT Scan Bone Scan EMG Other________________________________

Medical History (Circle) High Blood Pressure, Diabetes, Arthritis, Osteoporosis/penia, Cancer, Allergies, Heart condition, Pace Maker, Stroke, Pregnancy
Other including orthopedic conditions and surgeries:____
____
____
____
____

Pain rating: Indicate your usual level of pain by circling the appropriate number on the scale:

0____1____2____3____4____5_____6____7____8____9____10 **Worst Pain=**_______ **Least Pain=**_________
mild moderate extreme agony

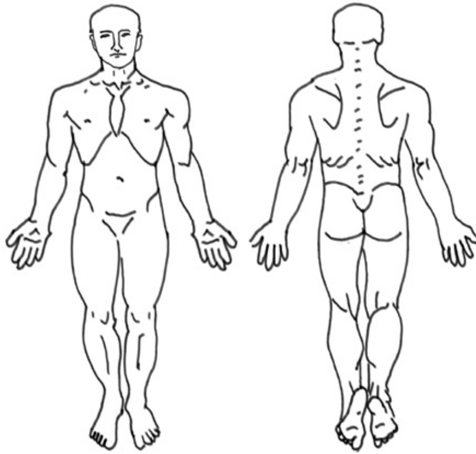
Does your pain?(circle) Throb Burn Stab Ache Other_______________________________________

Is your pain constant? Yes No

TURN PAGE OVER

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins and Needles	Burning	Stabbing	Aching
===	○○○	xxx	///	***



Does your pain radiate? Yes, where____ No

Numbness, tingling, or weakness? Yes, where_____________________________________ No

What makes your pain worse? ____

____

What makes your pain better?____

____

What is your goal for your treatment?____

What activity would you like to resume?____

How long has it been since you have been able to perform this activity? _____________________

When is your next Dr. appt.?_________________

Email (for receipt purposes only):____

Patient Signature:___________________________________ Date:_______________________

FOR THERAPIST USE ONLY
COMMENTS:
Initial Evaluation:____

____
____
____
____
____
____

Therapist Signature________________________________Date_____________________

TSM Towson Sports Medicine

University of Maryland Rehabilitation Network

Please provide a list of all your medications including prescription, over the counter, vitamins, and supplements, with dosage, frequency, and how administered (oral, injected, etc).

Medication	Dosage	Frequency	How Administered

Towson Sports Medicine Fall Risk Screening

Medicare has requested that we ask all of our patients the following questions. Please answer all of the questions.

Thank You

1. **Have you fallen in the past year? Yes No**
2. **How many times have you fallen in the past year? ______**
3. **Please describe any injuries you have sustained from a fall**
   ____
   ____
   ____
4. **Please describe the circumstances of your last fall**
   ____
   ____
   ____
   ____

Date:_____________________ Initial:_______________

Date:_____________________ Initial:_______________

Date:_____________________ Initial:_______________

CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Sports Medicine to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and/or mental condition.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health and Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$25.00** missed appointment fee. Please contact **410-337-8847** to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment.

Thank You!

I have read and understand the statements noted above.

Patient/Guardian/Responsible Party_____________________________ Date________

Please Print Your Name______________________________________ Date________

Towson Sports Medicine Representative_________________________ Date________

Notice of Exclusions from Medicare Benefits

NEMB

Notice: As part of the American Taxpayer Relief Act of 2012 Medicare Beneficiaries currently have a "soft cap" cap of $1,940 and a "hard cap" of $3,700 for Physical and Speech Therapies combined and a separate $1,940 for Occupational Therapy **per calendar year.** This means at $1,940 we must provide written justification for continued therapy and at $3,700 you will have to stop treatment until Medicare approval is received. This is only justified in **extreme** cases.

The purpose of this form is to inform you of this in advance and that these monies are based on what Medicare pays (allowable amount), not on what Towson Sports Medicine charges. We will track your charges and inform you when you are nearing these limits.

If you have received therapy (PT, OT, or Speech) at any other outpatient location for any reason in the same calendar year, those visits are included. Failure to tell us about previous outpatient PT, OT, or Speech Therapy visits may cause you to exceed this cap and be personally liable for charges incurred beyond the $1940 amount.

Though you may elect to continue to receive care at our facilities, you may become personally liable for charges incurred after an allowable amount of $1940 if **you do not qualify. Please ask your therapist if you do not fully understand this**.

If you have a secondary or supplemental plan, they may **or may not** pay for additional fees once Medicare monies have been exhausted if you do not qualify for an exception. **Please check with your plan to determine their individual policies**. We will make every effort to check as well prior to your first visit. It should be noted that all deductibles will continue to apply.

It will be our policy to keep track for you those allowable charges incurred at our center so you can make informed decisions.

I **have** received outpatient rehabilitation services since January 1, 2015 _____________ (initial)

(Please circle which therapies you have received OT PT Speech)

I **have not** received outpatient rehabilitation services since January 1, 2015 _____________ (initial)

By signing this form you are acknowledging that you have been informed of this Federal Policy and desire to receive rehab services at TSM.

Patient Name: _____________________________________ *Date:* ___________________

Patient Signature: ___________________________________ *Date:* __________________