KNEE PAIN APPLICATION

Name: _____ **Date:** _____

Nickname: _____ **Date of Birth:** _____ **Age:** _____ **Sex: M** ☐ **F** ☐

Address: _____

City: _____ **State**: _____ **Zip**: _____

Mobile Phone #: _____ **Home Phone #:** _____

Email Address: _____

Occupation (Current or Previous): _____ **Retired: Yes / No**

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____ **Marital Status: S M D W # of Children:** _____

In Case of Emergency: Contact Name: _____ **Phone #:** _____

How did you hear about our office? _____

What is your main health concern / condition coming in today? _____

When did this begin? _____

What makes it worse? _____

What makes it better? _____

How would you describe your symptoms? *(Circle any that apply)*

| Limping | Stiff | Swelling | Stabbing | Sharp | Grinding | Throbbing |

| Ache | Weakness | Tiredness | Electric Shocks | Cold | Burning |

| Numbness | Cramping | Dead Felling | Stings | Pins & Needles |

Is this condition interfering with any of the following? *Circle any that apply)*

| Daily Activities | Relationships | Hobbies | Exercise | Standing | Walking | Lifting | Sleep | Work |

Frequency of your Pain:

Constant (76 – 100&) ____ Frequent (51 – 75%) ____ Occasional (25 – 50%) ____ Intermittent (24% or less) ___

On average what level would you rate your overall knee pain?

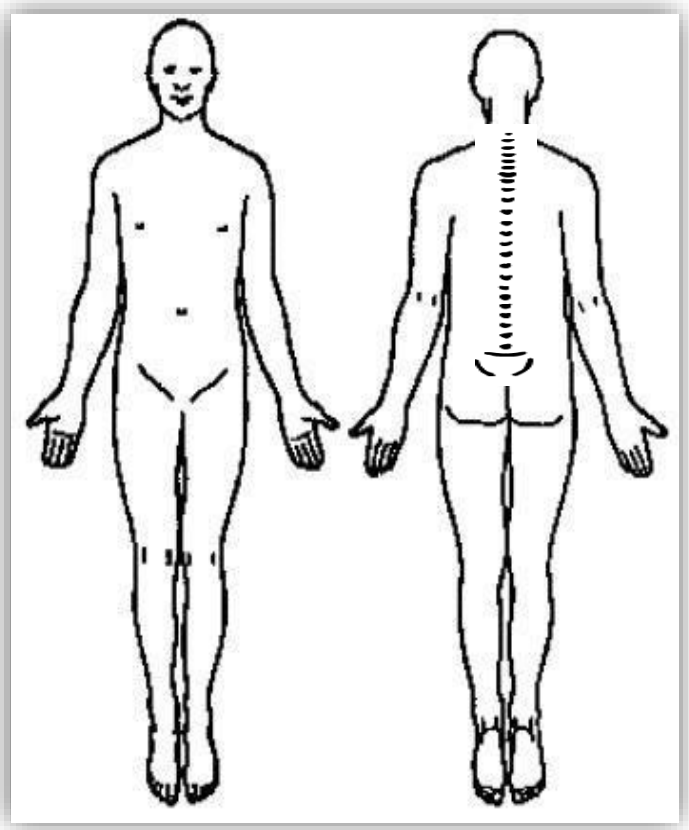
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

KNEE PAIN APPLICATION

Please indicate on this drawing the area(s) where you are currently experiencing symptoms:



Has your knee pain interfered with daily activities (walking, going up / down stairs, prolonged standing, sit to stand) for at least 6 months? _____

Have you tried pain and / or anti-inflammatory medications (i.e. Tylenol, Aspirin, Aleve, Advil, Meloxicam, Pain Creams) for at least 3 months without gaining long term relief from your symptoms? If yes, what have you tried?

_____

_____

Have you tried physical therapy for the affected knee(s) without long-term relief from your symptoms?

_____

Have you used a knee brace without long-term relief of your symptoms? What type of knee brace?

_____

_____

Have you tried Steroid / Cortisone Injection(s) to the knee without long-term relief? How many? _____

_____

KNEE PAIN APPLICATION

Please list below any Back, Knee, or Leg surgeries you've had and the dates: _____

_____

Have you had an MRI performed on your Legs/Knees/Feet? ☐ **No** ☐ **Yes, when?** _____

Has your doctor ever drained excess fluid from your affected knee(s)? _____

COMPREHENSIVE HEALTH HISTORY

☐ **Low Back Pain**	☐ **Vascular Leg Problems**	☐ **Heart Attack**	☐ **Shingles**
☐ **Sciatica**	☐ **Vascular Surgery(s)**	☐ **Stroke**	☐ **Kidney Disease**
☐ **Leg or Foot Pain/Numbness**	☐ **Joint Replacement**	☐ **High Blood Pressure**	☐ **Dialysis**
☐ **Neck Pain**	☐ **Knee Surgery(s)**	☐ **High Cholesterol**	☐ **Gout**
☐ **Hand Pain/Numbness**	☐ **Leg Fracture**	☐ **Cancer**	☐ **Other:** _____
☐ **Herniated/Bulging Disc**	☐ **Foot Surgery(s)**	☐ **Neuropathy**	
☐ **Spinal Arthritis**	☐ **Spinal Surgery(s)**	☐ **Diabetes (last A1c=_____)**	

Please list any / all prescription medications or vitamins you are currently taking (or you may attach a list):

Name	Dosage per Day

Name of your Primary Care Physician: _____ **Clinic:** _____

May we contact them with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to _____.
- I understand that _____ cannot file the knee treatments to insurance at this time.
- _____ will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patient's responsibility to contact their own insurance.

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Signature: _____ Date: _____

KNEE PAIN APPLICATION

FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ **Yes, a lot** ☐ **Yes, some** ☐ **No, not at all** ☐ **Indifferent**

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____

2._____

3._____

4._____

5._____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

_____

What would success mean to you in our office? _____

_____

_____

KNEE PAIN APPLICATION

APPOINTMENT PREPARATION AGREEMENT

Please initial your understanding and agreement for the following information.

Consent to Bringing a Spouse/Family Member

Knee Degeneration is a serious condition. Oxford Health and Wellness Center requests you bring a spouse or family member with you to your Initial (1st) and Follow-Up (2nd) appointments as there is a lot of information covered and two sets of eyes and ears are better than one.

I further agree that my spouse or family member will attend my first two appointments with me.
_____ *(Initial)*

Consent to Appropriate Dress Code

To effectively perform your exam(s) and treatment(s), Oxford Health and Wellness Center requests you to wear shorts or loose-fitted pants during your treatments. This will allow the Doctor and Therapy team to easily access your knee(s) to safely and effectively perform your exam(s) and treatment(s).

I further agree to wear appropriate attire during my appointments.
_____ *(Initial)*

Knee Function Questionnaire

These questions ask about limitations you may be experiencing due to your knee pain during the last 10 days. For each question, please circle only ONE answer that best describes your degree of limitation.

In the past 10 days, how has your knee pain affected….	**Not Affected/ Able to Complete**	**A Little/ Affected but Still Able to Complete**	**Quite a Bit/ Unable to Complete Some Days**	**Moderately/ Unable to Complete Most Days**	**Extremely/ Unable to Complete Task**
Your ability to walk without assistance (cane or walker) ?	1	2	3	4	5
Your ability to walk without a limp?	1	2	3	4	5
The distance you are able to walk?	1	2	3	4	5
Your ability to use stairs (up or down)?	1	2	3	4	5
Your ability to fall asleep or stay asleep through the night	1	2	3	4	5
Your balance or stability when walking or standing? (Falling, Unsure of footing)	1	2	3	4	5
Your ability to get up from a seated position?	1	2	3	4	5
Your ability to complete daily activities around your home? (laundry, dishes, cooking, etc.)	1	2	3	4	5
Your ability to complete errands? (grocery shopping, doctors appts, etc.)	1	2	3	4	5
Your ability to get in and out of a vehicle?	1	2	3	4	5

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Oxford Health & Wellness Center is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Oxford Health & Wellness Center, including its designated associates and assistants and hereby release Oxford Health & Wellness Center from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Oxford Health & Wellness Center any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuse and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Oxford Health & Wellness Center to administer care as deemed necessary to: _____.

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Oxford Health & Wellness Center and that I have been advised that Oxford Health & Wellness Center is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

A. it is determined that there is no insurance company obligation to pay for Oxford Health & Wellness Center's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Oxford Health & Wellness Center or to take other actions for the protection of the interest of Oxford Health & Wellness Center.
C. My attorney fails and/or refuses to agree to protect the interest of Oxford Health & Wellness Center as determined in its sole discretion; or
D. I fail to retain an attorney

Then payment of services at Oxford Health & Wellness Center will be made on a current basis and my bill paid in full within sixty (60) days from my last treatment.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of ten percent (10%) per annum. I further acknowledge and agree that Oxford Health & Wellness Center shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Oxford Health & Wellness Center.

By my signature below, I make the foregoing authorizations, assignments and agreements.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date Signed

Oxford Medical Health & Wellness Center
5144 College Corner Pike, Suite A
Oxford, OH 45056
p 513.524.4800
f 513.523.8631
oxfordmedical.medicfusion.com

Authorizations and Releases

Patient Name: _____

Consent to Professional Treatment
I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.
Initial ___

Consent to Perform and Interpret X-rays
I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.
Initial ___

Females: Regarding Possibility of Pregnancy
This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Females: Consent to X-Ray During Pregnancy
This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ___

Assignment of Benefits and Release of Records
I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial ___

Financial Obligation
I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.
Initial ___

Signature _____ Date _____