



The Centers

for Advanced Orthopaedics

Therapy Evaluation Form

Name: _____

Date: _____

DOB: _____

MRN: _____

Body part to be treated: _____

Date of injury (if any) _____ Approximate date of onset (if no injury) _____

Check which apply to your current condition:

☐ Work related injury

☐ Recurrence of previous injury

☐ Injury related to falling

☐ Motor vehicle accident

☐ Injury related to lifting

☐ Cause unknown

☐ Athletic/Recreational

☐ Other: _____

Have you had treatment for this area before? Yes No If yes, last date treated _____

Describe type of treatment: _____

Have you had surgery for this area? Yes No If yes, date of surgery _____

Type of Surgery: _____

Diagnostic Testing Performed? Xray MRI CT EMG

Please rate your pain on a scale of 0 to 10: At this moment ____ At its best ____ At its worst ____

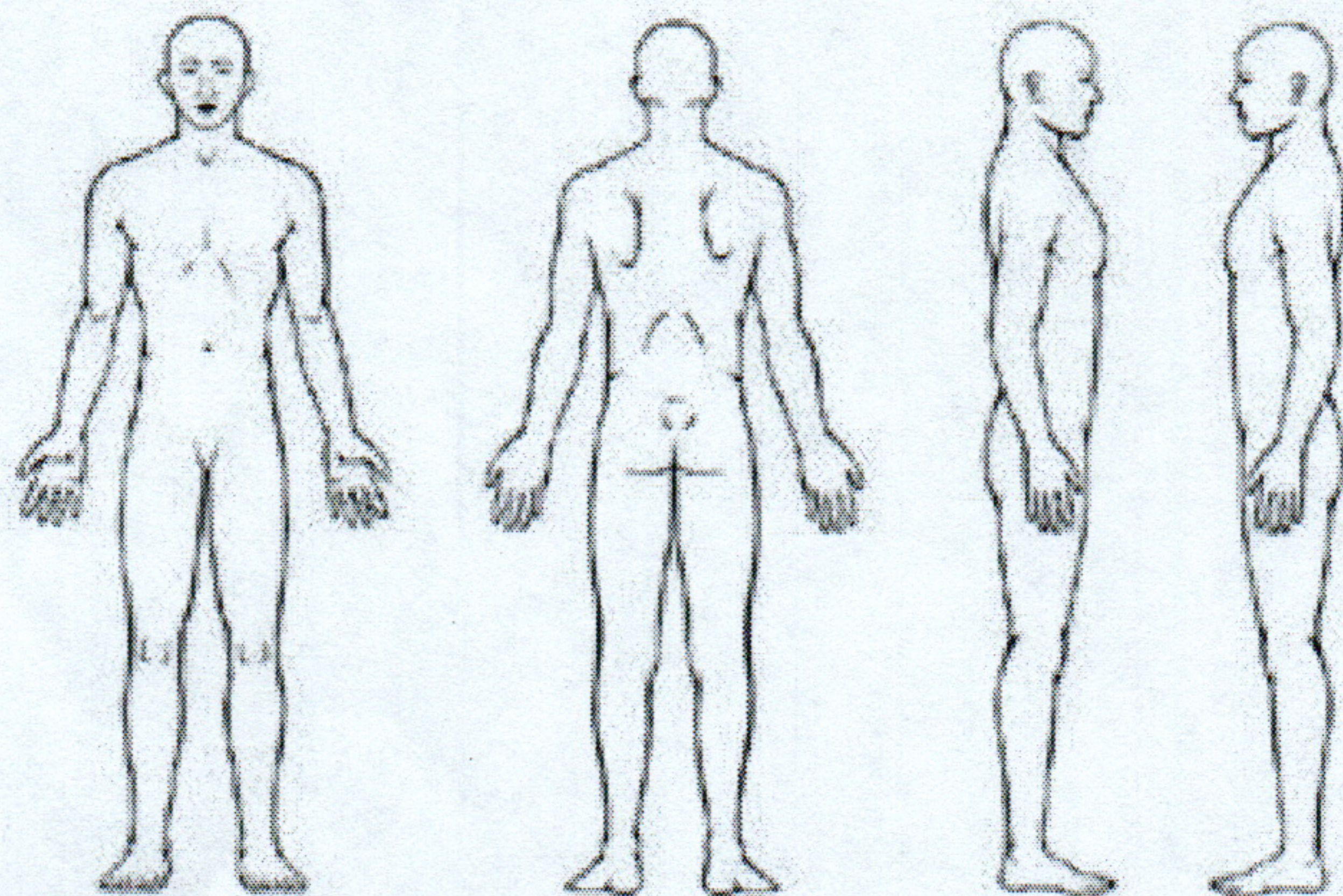
Are your symptoms currently (circle one): Getting better/ About the same/ Getting worse

What are your personal goals for therapy at this time:

PATIENT NAME: MATTHEW BLANKENSHIP DOB: 18/20/2000 DATE: 6/24/2026

Pain Diagram

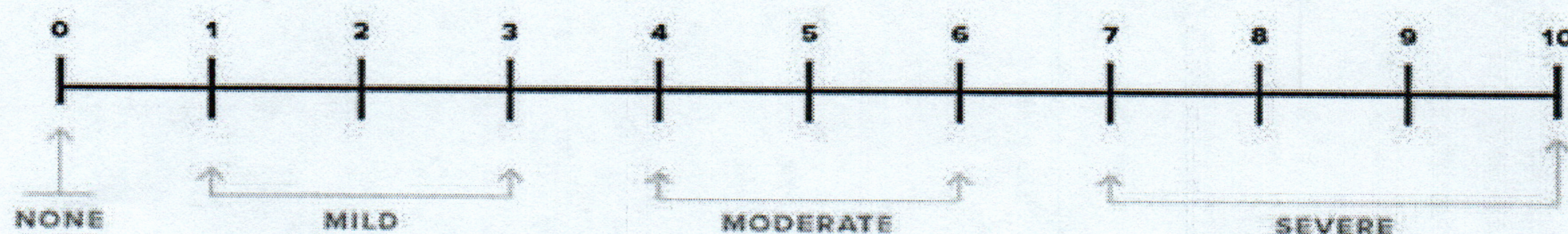
Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key
↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Please rate your pain number using the scale below: At this moment _____ At its best _____ At its worst _____

0-10 NUMERIC PAIN RATING SCALE



Please circle any symptoms you are currently experiencing:

Unexplained weight loss	Numbness/tingling	Changes in appetite	Fevers/chills/sweats
Depression	Shortness of breath	Dizziness	Headaches
Changes in bowel/bladder	Nausea/Vomiting	Poor balance/falls	Increased pain at night

Are your symptoms currently (circle one): Getting better / About the same / Getting worse

What are your personal goals for therapy at this time: _____

To the best of my knowledge, the above information is true and correct.

Patient or Patient Representative's Signature: _____ Date: _____

List any allergies (latex, drug, etc.): _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A If "Yes", please list your due date: _____

Do you have or have you ever had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Diabetes	☐	☐	Allergies to Asprin	☐	☐
High Blood Pressure	☐	☐	Allergies to Heat	☐	☐
Heart Disease	☐	☐	Allergies/Poor Tolerance to Cold	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heart Palpitations	☐	☐	Hernia	☐	☐
Pacemaker	☐	☐	Seizures	☐	☐
Headaches	☐	☐	Metal Implants	☐	☐
Kidney Problems	☐	☐	Dizziness/Fainting	☐	☐
Cancer	☐	☐	Recent Fractures	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Nausea/Vomiting	☐	☐
Urine leakage	☐	☐	ringing in your ears	☐	☐
Asthma/Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver/Gall bladder problems	☐	☐	Stroke/CVA	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other: _____	☐	☐	Depression/Anxiety	☐	☐

Any other conditions not listed above _____

MEDICATION QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____ DATE: _____

Do you take any prescription and/or over the counter medications? ☐ Yes ☐ No

If you do take any prescription and/or over the counter medication, please list each medication below:

[illegible]

Consent for Treatment and Authorization to Release Information

Consent for Treatment

I hereby authorize The Centers for Advanced Orthopaedics, through its appropriate therapy personnel, to perform an evaluation and treatment procedures, deemed necessary by the therapist, on me or the above named patient. This also authorizes, fabrication of a hand/upper extremity splint and serves as proof of receipt of such splint, if applicable, for myself or the above named patient.

Authorization to Release Information

I hereby authorize The Centers for Advanced Orthopaedics, to release to appropriate agencies, any information acquired in the course of my, or the above named patient's evaluation and treatment, necessary to process claims and pay The Centers for Advanced Orthopaedics directly for professional services rendered.

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I received or was offered the Notice of Privacy Practices for the Centers for Advanced Orthopaedics.

☐ Agree ☐ Decline

Date: _____

Patient Name: _____

Patient Account: _____

Signature: _____



PATIENT FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I agree to be responsible for the payment of all fees ("Fees") related to the services provided to me by Centers for Advanced Orthopaedics, LLC ("CAO") and its physicians and personnel (the "Services"). I understand that CAO will bill my insurance carrier, as a courtesy to me, based on the information I provide to CAO. Any portion of the Fees that is not paid by my insurance carrier to CAO shall remain my sole responsibility. Payment for the Services rendered to me by CAO is due and payable in full on the date of service.

If I have insurance coverage for the Services:

I hereby authorize CAO to submit claims to my insurance carrier for payment of all Fees for the Services, and agree to cooperate with CAO in providing all necessary information and authorization for submission of such claims.

I agree to pay to CAO, on the date of service, all co-pays, co-insurance and deductibles due under my insurance plan and all charges for Services that are not covered under my insurance plan.

I understand that CAO will invoice me for any balance of Fees remaining after my insurance plan has processed the claim, and I agree to pay any such balance to CAO within thirty (30) days of the date of the invoice.

If I do not have insurance coverage for the Services:

If I do not have insurance coverage for the Services or direct CAO not to bill my insurance for the Services (i.e., self-pay), I agree to be responsible for payment of all Fees to CAO for the Services in accordance with any good faith estimates provided to me.

Additional Fees: I hereby authorize the following additional fees to be charged to me by CAO under the following circumstances:

- **No-Show/Cancellation Fee:** I agree to be charged a no-show fee based on the type of appointment as set forth in the schedule below:

Visit Type	Advanced Cancellation Notice Required	Fee
Office Visit	Notify office 24 hours prior to appointment time.	\$25
Therapy Visit	Notify office 24 hours prior to appointment time.	\$35
Extended Office Visit*	Notify office 24 hours prior to appointment time.	\$50
Surgical/Procedure	Notify office 5 business days prior to scheduled surgery/procedure.	\$300
Functional Capacity Evaluation ("FCE")	Notify office 3 business days prior to scheduled FCE.	\$300

**Patient will be informed, at the time of scheduling when a visit is an "Extended Office Visit".*



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- **Returned Check Fee:** I agree to be charged a fee of \$25.00 if my check in payment of Fees hereunder is returned to CAO due to insufficient funds. After any such return, I agree to pay the remaining balance due by cash, credit card or money order.
- **Collection Fees (*this applies to Maryland and Virginia patients only*):** I agree to pay for all fees incurred by CAO in engaging a debt collector to collect on any outstanding balance of Fees that remains unpaid for at least ninety (90) days following the date of the applicable invoice.
- **Fees for Copies of Records:** I acknowledge that I may obtain electronic copies of most of my patient records on CAO's Patient Portal at no cost to me. If I request paper copies of my patient records or electronic copies of records not otherwise available on the Portal, I agree to pay fees for such copies that do not exceed the maximum amount allowed under applicable law.

Assignment of Benefits

I irrevocably assign to CAO all of my rights and benefits and any other interests that I have in my insurance plan in connection with the Services. I understand that this document is a direct assignment of my rights and benefits under such plan. I instruct my insurance plan to pay CAO directly for the professional or medical expense benefits payable to me, and, if direct payment is not permitted, to mail a check in my name to CAO, which I hereby irrevocably authorize CAO, as my special power of attorney, to endorse over to it in payment of the Fees.

Workers Compensation / Auto Accident Claims

I agree to complete all forms necessary for CAO to file workers compensation or auto accident/ PIP insurance claims on my behalf, and I agree to provide CAO with my personal health insurance information to be used in the event that such other coverage is denied.

Referrals

If I have an insurance plan (such as an HMO) that requires a referral for the Services, I understand that I must obtain the referral prior to my scheduled appointment. CAO will not obtain the referral on my behalf.



Agreement to Charge

I hereby authorize CAO to charge any credit or debit card I have given to CAO to pay for all co-pays, co-insurance and deductibles due for the Services and all unpaid Fees that are my responsibility hereunder, if I fail to pay any balance of Fees when due.

By signing below, I agree to all of the terms of this Patient Financial Agreement and Assignment of Benefits:

Signature of Patient or Parent/Legal Guardian of Patient

06/24/2026

Date