WELCOME TO THE ROC - RECONSTRUCTIVE ORTHOPEDIC CENTER OF HOUSTON

Questions about these instructions?
Call: **281-953-8399**
(8 am to 5pm CST)
www.rocmd.com

Reconstructive Orthopedic Center of Houston
1213 Hermann Dr. - Suite 380
Houston, TX 77004

Below you will find general information regarding our therapy department and your treatment. We hope this handout will provide information that will make your visit with us as pleasant and smooth as possible.

- **Hours of operation:** 8:00 am to 5:00 pm, Monday through Friday. The last appointment before lunch is at 11:00 am and the last appointment of the day is at 3:30pm.
- **If you require a specific time for your appointment:** We will accommodate your schedule when possible, but please schedule your times in advance (2 weeks at a time) to make sure the times are available for you.
- **Waiting for appointments to begin:** If you are early for your appointment it will be difficult for us to start your therapy early. We want all patients to receive their allotted time for treatment and have scheduled this accordingly.
- **Arriving late for appointments:** If you are late for your appointment, the therapist may reschedule you for another time as necessary. If you arrive on the wrong day, you will be rescheduled unless there is a treatment time available. Please be considerate of other patients; if you arrive late this interferes with their scheduled appointment time.
- **If you have to cancel an appointment:** Please cancel your appointments at least 24 hours in advance. We often have patient waiting to schedule so with 24 hours of notice we can rebook your appointment time that you had to cancel. If you are filing workmen's compensation and miss an appointment, we are obligated to send a notice to both your insurance company and the doctor that you missed your appointment. Missed visits must be capture in the same week.
- **Cell phones cannot be used inside the clinic** unless you work in an emergency profession where your phone is used to contact you in an urgent situation. Unnecessary phone calls limit you and the therapist's valuable treatment time.
- **Limiting visitors and children in the clinic:** Family and children need to wait in the waiting room due to the privacy and safety of themselves and our other patients. We have unfortunately found that children can be disruptive and may cause the patient not to get the proper therapy time, while family member take up seats and space that other patients may need.
- **Scheduling with your primary therapist:** Please schedule whenever possible with your primary therapist in order to ensure continuity of care. You will meet your primary therapist on your first day of therapy. Our therapists work closely with certified assistants (COTAs) who will be involved in your treatment. These assistants are trained in hand rehabilitation and carry out treatment plan outlined by your primary therapist. The primary therapist will be tracking your progress and making changes to your treatment plan as necessary. If you have any issue regarding your treatment you should always discuss it with your primary therapist.
- **Co-Payments and Splints are due at the time of service.** PPO and Self Pay individuals will need to make their payments after each session.
- **After each therapy visit, please check out at the front desk before you leave.** Your charge sheet will be processed by the secretary and any other treatment or insurance issue will be discussed.
- **If your insurance requires a referral from your PCP (Primary Care Physician)**, it will be your responsibility to confirm that there is a valid referral for each visit. In addition, you need to be aware that some insurance companies only allow 60 days of consecutive treatment per diagnosis per calendar year.
- **Parking is available in the covered garage for free.**

(Sign here) _____ I have read all of the above information and will comply with the rules and regulations above.

Our Therapists are:

Kathy Brou, OTR, CHT
Francisco Mendoza MOT, OTR, CHT
Amanda Rowell, OTR
Debra Miller, MHSPT, CHT
Joanna Ford, COTA

Therapy techs:

Carlos Zorrilla
Laura Montemayor
Maria Fajardo

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PATIENT CONSENT FORM

Patient's Name: _____

CONSENT TO TREATMENT

Knowing that I have a condition requiring Healthcare, I voluntarily consent to such care, including diagnostic procedures and medical treatment ordered by my physician. I am aware that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of treatments or examinations. ***Initial here_____***

ACCIDENTAL EXPOSURE OF HEALTHCARE WORKER

I understand that, if a healthcare worker is accidentally exposed to my blood or other bodily fluids, I will be tested for Hepatitis B, Hepatitis C, and/or HIV/AIDS without specific consent. Test results will be kept confidential to the extent allowed by law. ***Initial here*** _____

TOBACCO-FREE ENVIRONMENT

I am aware that Reconstructive Orthopedic Center of Houston prohibits the consumption, use of possession of non-prescribed drugs, alcohol, tobacco (including e-cigs) and weapons on Reconstructive Orthopedic Center of Houston's property. If non-prescribed drugs, alcohol tobacco (including e-cigs) vand weapons are found, they will be confiscated, and I may be charged immediately. Local police department will be notified, as necessary. ***Initial here*** _____

FINANCIAL RESPONSIBILITY

I promise to pay Reconstructive Orthopedic Center of Houston, PA physician, supplier and other practitioner for services rendered in accordance with bills or invoices presented. If I participate in an insurance benefit plan, I acknowledge financial responsibility, in accordance with the terms of the plan, for any services rendered that my insurance plan does not cover from payment either, because the plan deems such services not medically necessary or for any reason. ***Initial here*** _____

PLEASE CHECK ALL THAT APPLY:

☐ ASSIGNMENT OF BENEFITS: I irrevocably assign to Reconstructive Orthopedic Center of Houston all insurance benefits payable to me under my policies for hospital and professional services rendered to me.

☐ MEDICARE ASSIGNMENT: I certify that the information given to me in applying for Medicare benefits is correct. I request that payment of authorized benefits be made directly to Reconstructive Orthopedic Center of Houston.

☐ WORKMEN'S COMPENSATION: The Workmen's Compensation Commission regulates fees and charges for medical aid, hospital services and medicines. I understand that, if the Insurance carrier determines that my injury is not considered compensable and if I choose to continue with therapy with this knowledge, I will be responsible for the charges incurred.

☐ PHOTOGRAPH RELEASE: I consent to have audio or visual recordings in the form of photographs, illustrations, or videotapes made of me to be used for educational or research purposes. Initial here _____

☐ PERSONAL ITEMS: I have been advised to leave my personal items at home and assume full responsibility for any personal items that I can take to my therapy appointments. I understand that Reconstructive Orthopedic Center of Houston will not be responsible for any personal items that are lost, stolen or damaged. Initial here _____

This consent form is valid unless otherwise changed. I certified that I have read the above information, or that the information has been read or translated to me, and that I understand my rights and responsibilities as a patient at Reconstructive Orthopedic Center of Houston. All photocopies of this form shall be considered as originals.

_____ 07/27/2016

Signature of patient/ Guardian — Date

_____ 07/27/2016

Witness — Date

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PARKING POLICY

ROC of Houston Parking Policy and Guidelines for Patients

1. ROC Therapy will pay for parking on the day of your treatment session **only**.
2. A ROC of Houston validation ticket will be given when you are checked in for therapy. The front desk receptionist will issue this validate parking ticket. Upon providing proof of the garage ticket.
3. When using the validation, the parking ticket must be fed into the parking machine first, followed by the validation ticket.
4. ROC Therapy **WILL NOT** cover for parking for the following events:
    - You come to your appointment on the wrong day and you are not seen for therapy.
    - If you go to the physician for an office visit and do not receive therapy on that day.
    - You arrive 15 minutes or more late to your therapy appointment, you have not called and notified us that you were going to be arriving late and ROC cannot see you for your appointment due to scheduling conflicts. (For example, your therapist is seeing someone else at their appropriate time and no other therapist is available to see you when you arrive)
    - Your parking ticket is not from the Museum Medical tower parking.

_____ _____

Patient signature **ROC Front Desk Personnel**

07/27/2016
_____

Date

ROC THERAPY

PATIENT MEDICAL QUESTIONNAIRE

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Patient Information:

Last Name:	First Name:	M.I.	Date: 07/27/2016

Social History/Education History:

Occupation: | Are you currently employed? ☑ YES ☐ NO

Work requirements:

Any work restrictions? ☑ YES ☐ NO | What are they?

Where you working before your injury? ☑ YES ☐ NO

What type of home do you live in?	Do you have any of the following in your home?
☐ *Single Family Home*	☐ *Stairs with railings; How many stairs to enter the home?* ___
☐ *Apartment*	☐ *Stairs without railings*
☐ *Assisted Living*	☐ *Ramps*
☐ *Nursing Home*	☐ *Elevators*
Do you live alone? ☐ YES ☐ NO	Are you able to drive? ☐ YES ☐ NO

Do you have a regular exercise program? ☑ YES ☐ NO

If yes, what type of program and how frequently?

The following information is necessary in order to improve the quality of service you receive during your therapy visits. Please complete all questions.

Have you had a nurse or therapist come to your home/place of residence to treat you for any of the following:

a) *Bathing* ☐ YES ☐ NO
b) *Dressing* ☐ YES ☐ NO
c) *Wound Care* ☐ YES ☐ NO
d) *Exercise* ☐ YES ☐ NO
e) *Anything* ☐ YES ☐ NO

Is someone still coming to your house for any of the above? ☐ YES ☐ NO

If yes, then who?

THERAPY

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PATIENT MEDICAL QUESTIONNAIRE (CONTINUED)

Fill Out History Chart And Pain Level Scales

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ High Blood Pressure
- ☐ Allergies
- ☐ Other: _____
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Epilepsy/Seizures
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Arthritis
- ☐ Depression
- ☐ Broken Bones
- ☐ Joint Replacement
- ☐ Upper Limb Amputation
- ☐ Overweight, Obesity
- ☐ Dementia

Pain Scale:

We will ask you to grade your pain on a scale of **0 to 10**
We would like to inform you that we will be asking you what your pain level is prior to beginning a treatment, as well as during and following treatment.

0 = NO PAIN / 10 = WORST PAIN IN YOUR LIFETIME or you feel you have to go to the emergency room.

Circle where you would rank your pain **NOW**:

[X]	1	2	3	4	5	6	7	8	9	10

What is the **BEST** your pain has been over the past two weeks?

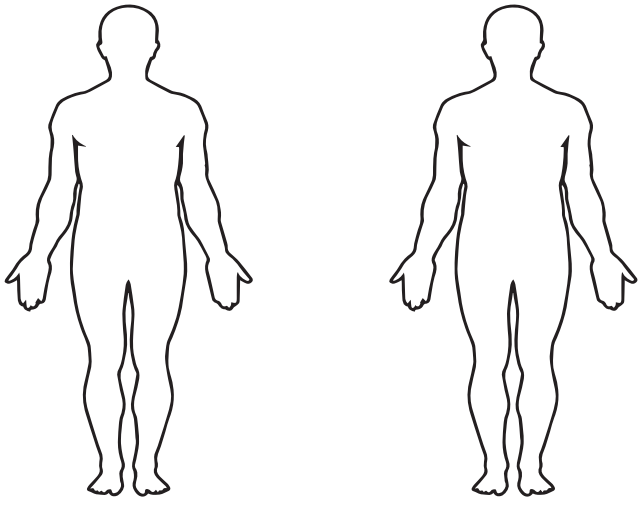
0	1	2	3	4	5	6	7	8	9	10

What is the **WORST** your pain has been over the past two weeks?

0	1	2	3	4	5	6	7	8	9	10

Mark your symptoms on the body diagram:

Severe Pain	XXXXXX
Moderate Pain	////////
Tingling	++++++
Numbness	OOOOO
Shooting Pain	--------



Front *Back*

THERAPY

FOTO PATIENT INTAKE SURVEY - FOOT, ANKLE, LOWER LEG (WITHOUT KNEE)

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We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the question based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, because of your affected foot/ ankle/ lower leg, do you or would you have any difficulty...	**Extreme Difficulty/ Unable To Do**	**Quite A Bit Of Difficulty**	**Moderate Difficulty**	**A Little Bit Of Difficulty**	**No Difficulty**
1. With any of your usual work, housework, or school activities?	☐	☐	☐	☐	☐
2. Getting into or out of the bath?	☐	☐	☐	☐	☐
3. Walking between rooms?	☐	☐	☐	☐	☐
4. Lifting an object, like a bag of groceries from the floor?	☐	☐	☐	☐	☐
5. Performing light activities around your home?	☐	☐	☐	☐	☐
6. Performing heavy activities around your home?	☐	☐	☐	☐	☐
7. Walking two blocks?	☐	☐	☐	☐	☐
8. Getting up or down 10 stairs (about 1 flight of stairs)	☐	☐	☐	☐	☐
9. Standing for 1 hour?	☐	☐	☐	☐	☐
10. Running on uneven ground?	☐	☐	☐	☐	☐

ROC THERAPY

THE DISABILITIES OF THE ARM, SHOULDER & HAND SCORE

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Clinician/Patient Information:

Clinician's Name (or ref)	Patient's Name (or ref)

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer every question based on your condition in the last week. If you did not have the opportunity to perform an activity in the past week, please make your best estimate on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week.

1. Open a tight or new jar	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
2. Do heavy household chores (eg wash walls, wash floors)	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
3. Carry a shopping bag or briefcase	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
4. Wash your back	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
5. Use a knife to cut food	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	☐ No Difficulty	☐ Mild Difficulty	☐ Moderate Difficulty	☐ Severe Difficulty	☐ Unable
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbor or groups?	☐ Not At All	☐ Slightly	☐ Moderate	☐ Quite a Bit	☐ Extremely
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	☐ Not Limited at All	☐ Slightly Limited	☐ Moderate Difficulty	☐ Very Limited	☐ Unable

Please rate the severity of the following symptoms in the last week

9. Arm, shoulder or hand pain	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
10. Tingling (pins and needles) in your arm, shoulder or hand	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

Thank you very much for completing all the questions in this questionnaire

The disabilities of the arm, shoulder & hand score: _____

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FOTO PATIENT INTAKE SURVEY - KNEE

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the question based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, because of your affected knee, do you or would you have any difficulty...	**Extreme Difficulty/ Unable To Do**	**Quite A Bit Of Difficulty**	**Moderate Difficulty**	**A Little Bit Of Difficulty**	**No Difficulty**
1. With any of your usual work, housework, or school activities?	☐	☐	☐	☐	☐
2. Getting into or out of the bath?	☐	☐	☐	☐	☐
3. Walking between rooms?	☐	☐	☐	☐	☐
4. Squatting	☐	☐	☐	☐	☐
5. Lifting an object, like a bag of groceries, from the floor?	☐	☐	☐	☐	☐
6. Performing heavy activities around your home?	☐	☐	☐	☐	☐
7. Walking two blocks?	☐	☐	☐	☐	☐
8. Getting up or down 10 stairs (about 1 flight of stairs)	☐	☐	☐	☐	☐
9. Standing for 1 hour?	☐	☐	☐	☐	☐
10. Running on uneven ground?	☐	☐	☐	☐	☐