PROGRESSIVE PHYSICAL THERAPY AND REHABILITATION

129 W. Wilson St., Suite 202
Costa Mesa, CA 92627
Tel: 949.631.0125 Fax: 949.631.0127

894 W. Town and Country Road Building "F"
Orange, CA 92686
Tel: 714.547.1140 Fax: 714.547.1144

NEUROLOGICAL HISTORY

PATIENT INFORMATION

Date: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

Gender: ○ Male ○ Female Birthdate: _____/____/_____ Age: _____ Marital Status: _____

Address: _____ Home Phone: (_____) _____

City_____ Work Phone: (_____) _____

State _____ Zip _____ Cell Phone: (_____) _____

Email: _____ Best # to reach you? ○ Home ○ Work ○ Cell

Would you like to receive text/voicemail appointment reminders? ○ Yes ○ No

Social Security:_____-_____-_____*(optional)* **Emergency Contact Phone #:** (_____) _____

Driver's License: _____ *Last Name:* _____

First Name: _____

Relationship: _____

Referring Physician: _____ City: _____ Phone:_____

Family Physician:_____ City:_____ Phone:_____

Employment Status (*18*): ○ Presently working full duty at same job ○ Unemployed
○ Presently working full duty at different job ○ Retired
○ Presently working restricted duty at same job ○ Student
○ Presently working restricted duty at different job ○ Other
○ Employed, but presently not working due to my condition
○ Previously employed and receiving disability benefits due to my condition

Occupation: ○ Professional/Executive ○ White Collar/Secretarial ○ Tradesperson ○ Laborer ○ Homemaker ○ Other

Employer: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Date of Injury/Onset of Symptoms: _____ Place of Injury: ○ Work ○ Auto ○ Other

INSURANCE INFORMATION

Insurance Company: _____ Phone: (_____) _____

Claim/Policy #:_____ Name of Primary Insured:_____

Group #: _____ Birthdate of Insured: _____

Relationship: _____

Secondary Insurance Company: _____ Phone: (_____) _____

Claim/Policy #:_____ Name of Primary Insured:_____

Group #: _____ Birthdate of Insured: _____

Relationship: _____

Patient Signature:_____ Date:_____

HEALTH QUESTIONNAIRE

In general, would you say your overall health right now is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

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 questions 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, does or would your health problem limit:	**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
Vigorous activities like running, lifting heavy objects, sports, running more than 5 miles?			
Walking more than a mile?			
Climbing several flights of stairs?			
Moderate activities, such as moving a table or pushing a vacuum cleaner?			
Lifting or carrying items like groceries?			
Bending, kneeling or stooping?			
Going on vacation?			
Climbing one flight of stairs?			
Lifting overhead to a cabinet?			
Getting in and out of a chair?			

12. Please indicate the number of surgeries for your primary condition. ○ None ○ 1 ○ 2 ○ 3 ○4+

13. How many days ago did the condition begin? ○ 0-7 Days ○ 8-14 Days ○ 15-21 Days ○ 22-90 Days ○ 91 Days to 6 Mos. ○ Over 6 mos. ago

14. Are you taking prescription medication for this condition? ○ Yes ○ No

15. Have you received treatments for this condition before? ○ Yes ○ No *(If yes, please provide information below)*

    Seen by: ○ Physical Therapist ○ Chiropractor ○ Medical Doctor ○ Other _____

    When? _____

    Tests done/date: ○ X-rays Date: _____ ○ CT Scan Date: _____

    ○ MRI Date: _____ ○ Other _____

16. This is a statement other patients have made. ***"I should not do physical activities which (might) make my pain worse."***
    Please rate your level of agreement with this statement below. (✓*response*)

    ○ Completely Agree
    ○ Somewhat Agree
    ○ Unsure
    ○ Somewhat Disagree
    ○ Completely Disagree

17. How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ○ At least 3 times a week ○ Once or twice per week ○ Seldom or never

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18Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- ○ Arthritis (rheumatoid / osteoarthritis)
- ○ Osteoporosis
- ○ Asthma
- ○ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- ○ Angina
- ○ Congestive heart failure (or heart disease)
- ○ Heart attack (Myocardial infarction)
- ○ High blood pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐Headaches
- ☐ Diabetes Types I and II
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Hearing impairment (very hard of hearing, even with hearing aids)
- ☐ Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, bladder, prostate, or urination problems
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐Other disorders
- ☐ Hepatitis / AIDS
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer

1. Height: _____ ft. _____ in. Weight: _____ lbs.

<u>Pain Assessment:</u>

Is pain a symptom: ○ No (If response is no, you are finished with your survey).
○ Yes (If yes, please complete the remain of the questions below)

Rate the level of pain you have had in the last 24 hours (*please circle response*):

None 0 1 2 3 4 5 6 7 8 9 10

Over the past month, how would you rate your pain when it was the best? (*please circle response*)

None 0 1 2 3 4 5 6 7 8 9 10

Over the past month, how would you rate your pain when it was the worst? (*please circle response*)

None 0 1 2 3 4 5 6 7 8 9 10

Is your pain constant? ○ Yes ○ No

Provide the percentage of time you experienced pain in the last 24 hours (*please circle response*):

None 10% 20% 30% 40% 50% 60% 70% 80% 90%

# of days over the last week you experienced pain (*please circle response*): 1 2 3 4 5 6 7

# of weeks you have experienced pain: _____

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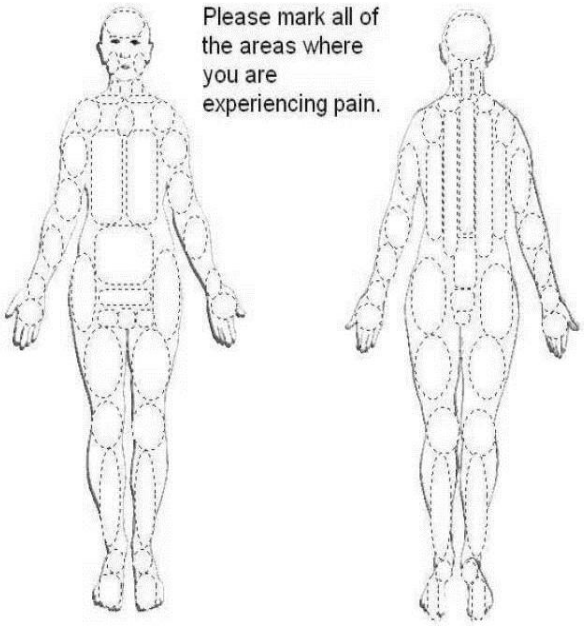
Please select all that describes your pain and circle the intensity for each one selected:

Description of Pain	Intensity		
Throbbing	Mild	Moderate	Severe
Shooting	Mild	Moderate	Severe
Stabbing	Mild	Moderate	Severe
Sharp	Mild	Moderate	Severe
Cramping	Mild	Moderate	Severe
Gnawing	Mild	Moderate	Severe
Hot / Burning	Mild	Moderate	Severe
Aching	Mild	Moderate	Severe
Heavy	Mild	Moderate	Severe
Tender	Mild	Moderate	Severe
Splitting	Mild	Moderate	Severe
Tiring / Exhausting	Mild	Moderate	Severe
Sickening	Mild	Moderate	Severe
Fearful	Mild	Moderate	Severe
Punishing / Cruel	Mild	Moderate	Severe

Please mark all of the areas where you are experiencing pain.



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Insurance Authorization Information – OFFICE USE ONLY					
Diagnosis:			Date:	Initials:	Spoke to:
Patient Co-Ins %:	Patient Co-Pay $:		Deductible Start Amount $:		Amount Met: $
LIMITS	Visits Per Year:	Consec Days Per Year:	Amount Per Year:		Out of Pocket:
Visits are combined with: □ PT □ OT □ Chiro □ SLP □ Acupuncture □ Other			# Visits remaining:		Effective Date:
Billing Address:		City:		State:	Zip:
Authorization Phone #:			PT Auth. #		
Discussed Benefits with Patient: Date:_____ Initials:_____					
Notes:					

Patient Authorization, Release and Financial Responsibility

I authorize treatment by the staff at Progressive Physical Therapy and Rehabilitation and authorize the release of information to other health professionals and to my insurance company. I authorize payment to be made directly to Progressive Physical Therapy and Rehabilitation. I do not hold Progressive Physical Therapy and Rehabilitation responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and my insurance company. If for any reason my insurance company denies coverage and/or payment, I understand that I am financially responsible for the entire balance of my account and that my balance will be paid in a timely manner. I understand any co-payments and deductibles will be paid at the time of service. **I have read the above estimation of benefits from my insurance company and agree to verify this information by reading my insurance benefits book or contacting my insurance company.**

Patient Signature: _____ **Date:** _____

Cancellation/No Show Policy

To ensure that we are able to continue providing the highest quality of care and to help minimize patient waiting time, we require a 24-hour advanced notification for any appointments cancelled. If the patient fails to comply with this policy or fail to show up for the scheduled appointment, Progressive Physical Therapy will charge a $45.00 fee for all appointments missed. This fee will be due at the beginning of the next scheduled visit.

Initials:_____

Returned Checks

Checks returned due to insufficient funds will be liable to a $30 processing fee for the first occurrence. The second occurrence will be charged a $50.00 fee and each additional payment must be made using a different form of payment, such as cash or credit card. Any unpaid balances beyond 60 days will be turned over to a collections agency.

Initials:_____

Written Reports and Letters

I understand that any report or letter beyond an initial evaluation report or a progress report will be subject to a $50.00 fee.

Initials:_____

Receipt of Notice of Privacy Practices Acknowledgment

I acknowledge that I have read, or have had the opportunity to read, and understand the Notice of Privacy Practices that was provided for me.

Initials:_____

Progressive Physical Therapy and Rehabilitation

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Orange, CA 92868
714.547.1140

129 W. Wilson St., Suite 202
Costa Mesa, CA 92627
949.631.0125

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization except in instances required by law. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you feel that your privacy rights have been violated, you may file a written complaint at the address listed below. Under no circumstances will the fact that you have filed a complaint affect the services provided to you by Progressive Physical Therapy and Rehabilitation, Inc.

Progressive Physical Therapy and Rehabilitation
129 W. Wilson St., #202
Costa Mesa, CA 92627
Attn: Privacy Officer
949.631.0125
Or fax to: 949.631.0127