Progressive Physical Therapy Plus

12665 Garden Grove Blvd Suite 603
Garden Grove, CA 92843
Phone 714*643*9012 Fax 714*643*9015

Patient Information

Last Name:_____ First Name:_____ MI: _____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:( )_____-_____ Work Phone:( )_____-_____ Cell Phone:( )_____-_____

Please indicate the best # to reach you: Home/Work/Cell Email:_____
Would you like text or email reminders for your appointments Yes___ No_____

Date of Birth:____/____/_____ Age:____ M/F:____ Marital Status:_____
Social Security:_____-____-_____(optional) Driver's License:_____
Occupation:_____ Employer:_____
Employer Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact Phone Number: ( ) _____-_____

Last Name:_____ First Name:_____ Relationship:_____

Referring Physician:_____ City:_____ Phone:( )_____-_____
Family Physician:_____ City:_____ Phone:( )_____-_____
Date of Injury/Onset of Symptoms:_____ How did you hear about us?_____
Place of Injury: Work/Auto/Other State:_____ Employment Status:_____ Student: Y/N

Insurance Information

Insurance Company:_____ Phone Number:( )_____-_____
Claim/Policy #:_____ Group #:_____
Name of Primary Insured:_____ DOB:___/___/___ Relationship:_____

Secondary Insurance Company:_____ Phone Number:( )_____-_____
Claim/Policy #:_____ Group #:_____
Name of Primary Insured:_____ DOB:___/___/___ Relationship:_____

Have you received physical therapy in this calendar year? Yes No
If yes, when and how many treatments?_____

Have you had any injections for your current problem? Yes No If yes, Location:_____
Do you have any surgical implants (plastic, metal, etc…)? Please explain:_____

What are your goals for physical therapy?_____

Medications currently taking:_____
_____

Patient Signature:_____ **Date**:____/____/_____

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 understand that my visits have been pre-authorized by my Workers' Comp carrier and all payments will be made them. I understand that I will not be held financially responsible for any unpaid visits.

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 $25.00 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:_____

FOTO Patient Intake Survey
Neck

Staff to Complete
PATIENT NAME:_____ Patient ID: _____

Gender: Male / Female Date of Birth: _____/_____/_____ Clinician: _____

Body Part _____ Impairment _____ Care Type _____

Payer Source _____ *(Type of Plan such as Preferred Provider, HMO, WC, Auto Insurance, etc.)*

Date of Survey: ____/____/_____

The following assessment will ask you about difficulties you may have with certain activities.
It's an important part of your evaluation. It will help us:

- understand how your condition is affecting your activities, and
- develop treatment goals with you.

Please answer the questions with respect to the problem for which we are seeing you. Respond based on how you have been over the past few days.

Today, does or would your health problem limit:	**Extreme Difficulty or Unable to Perform**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**Little Bit of Difficulty**	**No Difficulty**
1. Looking up to see a bird?					
2. Performing personal care activities like washing, dressing, bathing?					
3. Moving your head quickly, such as following a loud noise?					
4. Performing recreational activities that require little effort (eg, card playing , knitting, etc.)?					
5. Turning to look behind you to drive a car?					
6. Turning over in bed?					
7. Sitting and reading a book for 1 hour?					
8. Changing a light bulb overhead?					
9. Sitting, performing light desk work for 8 hours?					
10. Performing recreational activities in which you take some force or impact (eg, golf, hammering, tennis, etc.)?					

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

0 1 2 3 4 5 6 7 8 9 10

(None) (Pain as bad as it can be)

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 ☐ 15-21 ☐ 22-90 ☐ 91 days to 6 mos. ☐ Over 6 mos. ago

Patient Name: _____ Patient ID _____

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

15. Have you received treatments for this condition before? ☐ Yes ☐ No

16. 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

17. Other 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)
- ☐ Pacemaker
- ☐ Seizures
- ☐ 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, Tuberculosis, HIV, AIDS, or other blood-borne condition
- ☐ Prior surgery
- ☐ Prosthesis / Implants
- ☐ Sleep dysfunction
- ☐ Cancer
- ☐ None of the above

18. Height (Required): _____ ft. _____ in. Weight (Required): _____ lbs.

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%

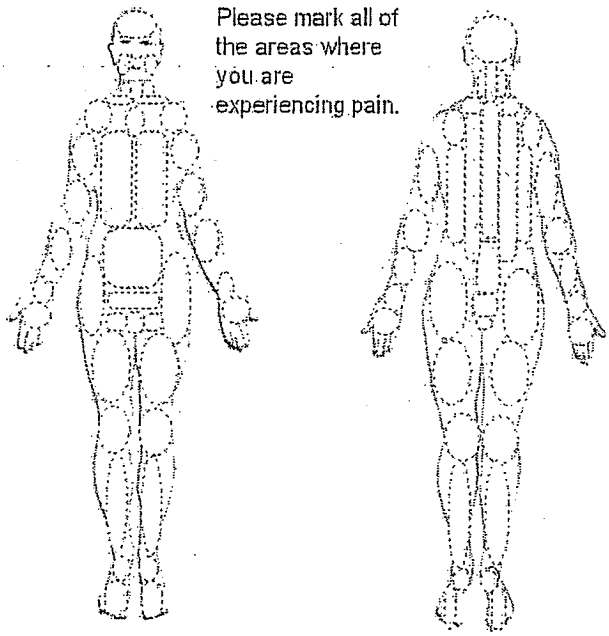
# of days over the last week you experienced pain (*please circle response*): 1 2 3 4 5 6 7

# of weeks you have experienced pain: _____

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.



Progressive Physical Therapy and Rehabilitation

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.