

# Progressive Physical Therapy Plus

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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: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Chiro <input type="checkbox"/> SLP <input type="checkbox"/> Acupuncture <input type="checkbox"/> 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: \_\_\_\_\_

## 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, because of your back problem, do you or would you have any difficulty at all...	Unable to perform	Extreme difficulty	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Performing any of your usual work, housework, or school activities?						
2. Performing your usual hobbies, recreational, or sporting activities?						
3. Performing heavy activities around your home?						
4. Bending or stooping?						
5. Lifting a box of groceries from the floor?						
<b>Does or would your back problem limit:</b>	<b>Yes, limited a lot</b>	<b>Yes, limited a little</b>	<b>No, not limited at all</b>			
6. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?						
7. Moderate activities like moving a table, pushing a vacuum cleaner, bowling, or playing golf?						
8. Lifting or carrying items like groceries?						
9. Attending social events?						
10. 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

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

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

11. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight: \_\_\_\_\_ lbs.

**Pain Assessment:**

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 best? (*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%

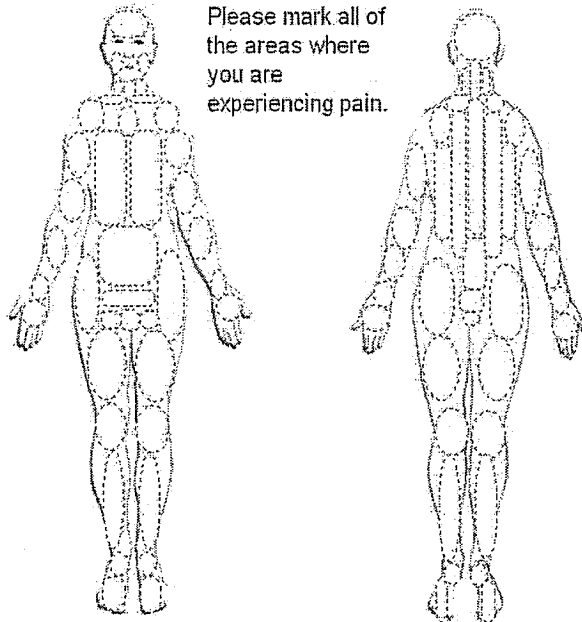
# of days over the last week you experienced pain (*please circle response*): 1 2 3 4 5 6 7

# of weeks you have experienced pain: \_\_\_\_\_

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

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

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.