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:_____

Office Use Only

MRN:

PATIENT HISTORY - LYMPHEDEMA

Patient's Name (First, Middle, Last)	Today's Date (mm/dd/yyyy)

Who referred you for lymphedema evaluation/treatment? *Please state referring physician name and contact information.*

Have you had any physical therapy for the same condition for which you are here today? ☐ YES, ☐ NO. If yes, please indicate where and when:

While you are treated at this facility, you will be asked to follow a program at home. This consists of wearing bandages 23 hours/day, meticulous skin care to avoid infections, and exercises and self massage to facilitate lymph flow. Are you prepared to follow such a program? ☐ Yes ☐ No

Do you have someone who can assist you with your home lymphedema treatment if you are unable to do it yourself? *(this will include bandaging the affected area(s), skin care and self massage)* ☐ YES, ☐ NO

CURRENT CONDITION(S)/CHIEF COMPLAINTS:

Is your Lymphedema:

☐ Primary (born with lymphedema OR onset during childhood/puberty/adult without an apparent reason)

☐ Secondary (due to cancer surgery or radiation treatment OR resulting from injury, infection, other surgeries, accident, wt. gain)

☐ Unknown

At what age did swelling first occur	At birth: ☐ Yes ☐ No	If not at birth what year did the swelling begin?

Did the swelling begin: ☐ Gradually ☐ Suddenly

Which area(s) is/are affected? Check all that apply.	☐ Left arm ☐ Left leg ☐ Neck/face ☐ Breast ☐ Right arm ☐ Right leg ☐ Genitalia ☐ Trunk
If you had breast cancer surgery please check/fill all that apply: ☐ Right ☐ Left ☐ Bilateral	☐ Lumpectomy ☐ Mastectomy ☐ Surgery date:_____ ☐ # lymph nodes removed:_____ ☐ # positive:_____
If you had surgery/treatment for other types of cancer please check/fill all that apply: Area:_____	☐ Surgery date:_____ ☐ # lymph nodes removed:_____ ☐ # positive:_____

How long after surgery (breast or other) did your swelling begin? _____

Have you undergone any of the following treatments? If 'yes' when, how much and what area? ☐ None

Treatment type?	When?	How much?	What area?
☐ Radiation			
☐ Chemotherapy			
☐ Hormonal			
☐ Other			

If you did NOT have cancer surgery, what do you think caused the onset of your swelling?

☐ Infection ☐ Trauma (injury) ☐ Venous insufficiency ☐ Post-surgery ☐ Weight gain ☐ Immobility
☐ Liposuction ☐ Primary/congenital ☐ Post-childbirth ☐ Lipedema ☐ DVT/clot ☐ Congestive Heart Failure
☐ Other:

Have you had any tests for this problem: ☐ X-ray ☐ MRI ☐ Lymphoscintigraphy ☐ Doppler ☐ Ultrasound (abdominal/venous)

Since the first onset of your swelling have you had any infections in the affected limb(s)? ☐ Yes ☐ No If yes # times: _____	Ever been hospitalized to treat your infection? ☐ Yes ☐ No If yes, # times hospitalized to treat the infection? _____ Are you currently taking preventative antibiotics? ☐ Yes ☐ No
Do you have any of the following issues in relation to your swelling?	☐ Pain ☐ Numbness ☐ Limited motion ☐ Skin issues ☐ Stiffness ☐ Heaviness ☐ Itching ☐ Weeping
As a result of your edema are you having difficulties:	☐ Dressing ☐ Bathing ☐ Sleeping ☐ Walking ☐ Driving ☐ Standing ☐ Reaching ☐ Reaching ☐ Sitting ☐ Reaching ☐ Chores ☐ Meal prep
What increases your swelling?	
What decreases your swelling?	
Does your swelling every go away? ☐ Yes ☐ No	If 'yes' what makes it go away? -

TREATMENT

Have you been treated previously for your swelling? If 'yes' when and how? ☐ Yes ☐ No	
How are you currently managing your swelling?	☐ Self-manual lymph drainage ☐ Bandaging ☐ Exercise ☐ Compression garments ☐ Skin care ☐ Nothing

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.