

PROGRESSIVE PHYSICAL THERAPY AND REHABILITATION

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

12665 Garden Grove Blvd., #603
Garden Grove, CA 92843
Tel: 714.643.9012 Fax: 714.643.9015

15771 Rockfield Blvd., Suite 150
Irvine, CA 92618
Tel: 949.750.8499 Fax: 949.446.6294

KNEE 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: _____

KNEE OUTCOME SURVEY:

Did you have surgery for this issue prior to receiving therapy: Yes No

To what degree does each of the following symptoms affect your level of activity:

For each row, mark the one box which most closely describes your current condition:

		I do not have this symptom	I have the symptom but it does not affect my activity	The symptom affects my activity slightly	The symptoms affects my activity moderately	The symptom affects my activity severely	The symptoms prevents me from all daily activity
1.	PAIN						
2.	STIFFNESS						
3.	SWELLING						
4.	KNEE GIVES WAY: BUCKLING OR SHIFTS						
5.	WEAKNESS						
6.	LIMPING						

Functional limitations with activities – How does your knee affect your ability to:

For each row, mark the one box which most closely describes your current condition:

		Activity is not difficult	Activity is minimally difficult	Activity is somewhat difficult	Activity is fairly difficult	Activity is very difficult	I am unable to do the activity
1.	WALK						
2.	GO UP STAIRS						
3.	GO DOWN STAIRS						
4.	STAND						
5.	KNEEL ON FRONT OF YOUR KNEE						
6.	SQUAT						
	SIT WITH YOUR KNEE BENT						
	RISE FROM A CHAIR						

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,
- 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

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 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*):

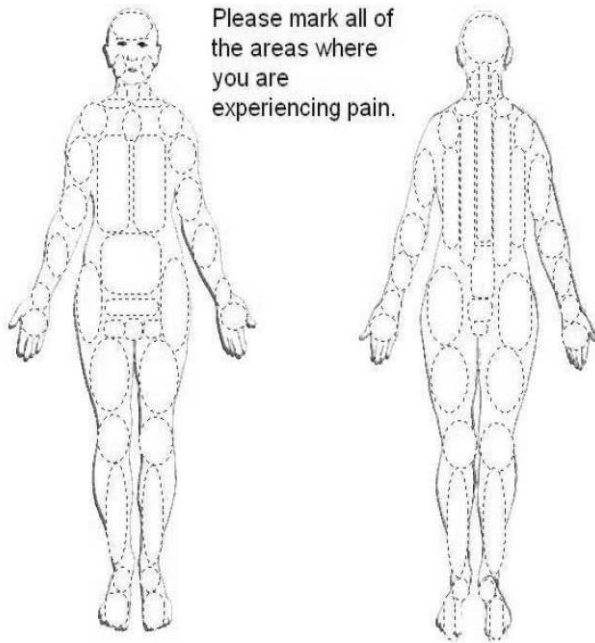
None 10% 20% 30% 40% 50% 60% 70% 80% 90%

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: _____

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

Description of Pain	Intensity		
	Mild	Moderate	Severe
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



CONTINUITY OF CARE FORM

We understand that many patients have a team of doctors working in conjunction with their medical care. To ensure continuity of care, we would like to be able to send treatment information and progress reports to your other health care providers. By signing below, you give Progressive Physical Therapy and Rehab permission to release this information.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

REFERRING PHYSICIAN:

Phone #: _____

FAMILY PHYSICIAN/INTERNIST:

Phone #: _____

ORTHOPEDIC SURGEON:

Phone #: _____

SPORTS MEDICINE PHYSICIAN:

Phone #: _____

PAIN MANAGEMENT SPECIALIST:

Phone #: _____

RHEUMATOLOGIST:

Phone #: _____

NEUROLOGIST:

Phone #: _____

OTHER (please specify):

Phone #: _____

Insurance Authorization Information – OFFICE USE ONLY				
Date:	Initials:	Spoke with:	Call ref#:	
Patient Co-Ins %:	Patient Co-Pay \$:	Deductible Amount:	Amount Met:	
Visits Per Year:	# Visits Used:	Out of Pocket Amount:	Amount Met:	
Visits are combined with: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Chiro <input type="checkbox"/> SLP <input type="checkbox"/> Acu <input type="checkbox"/> Hydro <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulm		RX/Referral Req:	Effective Date:	
Billing Address:		City:	State:	Zip:
Instructions for Auth:			PT Auth. #	
Notes:				
Discussed Benefits with Patient: _____ Date:_____ Initials:_____				

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: _____

Informed Consent and Release of Liability

I give consent to Progressive Physical Therapy and Rehabilitation to provide and perform therapeutic procedures, tests, exercises and other related services that are considered necessary. I fully understand and acknowledge that there are inherent risks and hazards associated with my participation of my therapy program and in the use of the equipment in this facility. These risks may include, but are not limited to, bodily injury, increased pain and/or discomfort, aggravation of my injury/condition, sprains/strains, fractures, partial or total paralysis, or death. I will take full responsibility for any losses and/or damages that may incur during my treatment. I will release, waive and discharge Progressive Physical Therapy and Rehabilitation, Inc. and/or its owners, employees, volunteers, and administrators from any and all liability, lawsuits and claims that may or may not be in connection to my participation in my therapy.

Initials:_____

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. Barring any emergencies or special circumstances, 3 or more consecutive no-shows/last minute cancellations will result in a stoppage of therapy.

Initials:_____

Written Reports and Letters

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

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:_____

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:_____

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., Suite 202
Costa Mesa, CA 92627
Attn: Privacy Officer
949.631.0125
Or Fax to 949.631.0127