Costa Mesa Physical Therapy | Specialized Physical Therapy

Patient Information:

Last Name: ___________________________________ First Name: _____________________________ MI: _______

Address: __________________________________ City: ___________________ State: _______ Zip: ______________

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: ____________________

Date of Birth: ______________________ SSN: ___________________________ Marital Status: ___________________

Gender: M / F Email: ________________________________ Referring Doctor: ______________________________

Emergency Contact:

Last Name: ___________________________________ First Name: ____________________________

Phone: _________________________ Relationship:______________________________________

Employer:

Name: _______________________________________ Phone: _______________________________

Address: _______________________________City: _____________________ State: __________ Zip: ___________

Insurance, Financial, and Office Policy:

ASSIGNMENT OF INSURANCE BENEFITS:

I, HEREBY, AUTHORIZE Costa Mesa Physical Therapy (CMPT) / Specialized Physical Therapy (SPT), to furnish information to insurance companies concerning my treatment. I, hereby, assign all payments for services rendered, to Health Works Physical Therapy, Inc. dba Costa Mesa Physical Therapy (CMPT) and HW Physical Therapy dba Specialized Physical Therapy (SPT).

Initial Here:_______

WORKERS' COMPENSATION CLAIMS:

If you claim Workers' Compensation benefits and are subsequently denied such benefits for any reason, you will be held responsible for the total charge amount for service rendered, to CMPT and/or SPT.

Initial Here:________

CANCELLATION AND NO-SHOW:

We require 24 hours notice in the event of a cancellation. **Failure to provide such notice will result in a charge of $40 for a physical therapy visit missed**. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. **Initial Here: _______**

As a courtesy to our patients, we will contact your health insurance to obtain authorization and verification of coverage, then we will provide you with an ***estimate*** of anticipated out-of-pocket costs that you may expect to incur during your treatment at CMPT and/or SPT. We will also bill your insurance company on your behalf.

We strongly encourage you to contact your insurance company at the start of your treatment to verify your insurance coverage and benefit estimates.

We require that arrangements for payment of your estimated share of your bill be made today. If your insurance company does not remit payment for services within 60 days, we reserve the right to bill you directly for the entire cost of the services. In the event that your insurance company requests a refund of their portion of the payments made to CMPT and/or SPT, then you may be responsible for payment of the amount refunded. If, for any reason, payments are made directly to you by your insurance company for the services billed by CMPT or SPT, you will promptly remit such payment to CMPT or SPT. Should formal collections procedures become necessary, you will be responsible for any additional costs incurred due to such collections actions. CMPT/SPT assumes no liability for any errors made by your insurance company in determination of your actual benefits. These benefits have been reviewed with you and you agree to pay your portion of the bill.

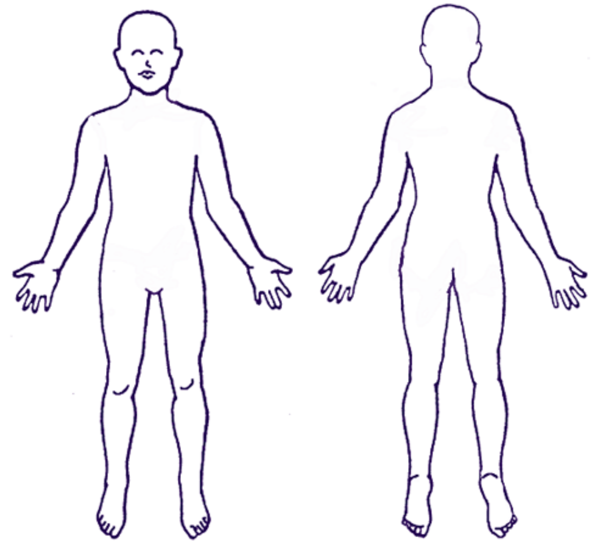
☐ **Will pay each visit** ☐ **Will pay weekly in advance**

Estimated patient payment / copay / deductible: $____

I understand that I am financially responsible for any balance due. **Initial Here: _________**

Type of Injury____

Type of Surgery & Date____



Previous treatments for this condition______________________________

____

Have you received physical therapy for this condition? Yes/No

Have you received Home Health Care this year? Yes/No

Have you had an imaging performed related to this condition?

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Ultrasound
- ☐ Doppler

Describe the type of pain you are having: Sharp - Burning - Aching - Tingling - Numbness - Other__________________________

Rate your pain (0=no pain, 10=severe): 0 1 2 3 4 5 6 7 8 9 10

Have you recently noted?

- ☐ Weight Gain/Loss
- ☐ Weakness:____________
- ☐ Pregnant
- ☐ Pain at night
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Cramps in legs
- ☐ Fatigue
- ☐ Numbness/Tingling:
- ☐ Change in vision or hearing
- ☐ Insomnia
- ☐ Pain after eating

Do you have or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains/Strains
- ☐ Heart Problems/Pacemaker
- ☐ Blood Clots
- ☐ Bruising/Bleeding
- ☐ Indigestion/Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma
- ☐ Leg Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Irregular Blood Pressure
- ☐ Car Accident
- ☐ Lung Disease
- ☐ Urinary Problems
- ☐ Allergies
- ☐ Any previous injuries that may affect current care____

Explain any items indicated above____

____

Are you currently taking any medication? If yes please list____

____

What do you hope to get out of physical therapy? Goals? ____

CONSENT FOR CARE AND TREATMENT:

Your Physical Therapist will complete an evaluation by interview and examination, after which your individual treatment program will be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent, for CMPT and/or SPT to furnish and provide physical therapy treatment considered necessary and proper in the professional evaluation and care of my condition.

<u>CONSENT FOR TREATMENT OF A MINOR</u>

As parent and/or legal guardian, I authorize CMPT/SPT to treat the minor as a physical therapy patient, even when I am not present. Parent/Guardian Name:___________________________________ **Parent/Guardian Initials:** _______

I authorize release of information requested by my insurance plan for payment.

I hereby acknowledge that I have received a copy of the **Notice of Privacy Practices** and I understand that CMPT/SPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, and evaluating the quality of services provided and any administrative operations related to treatment or payment. You have the right to revoke or restrict this consent after this, the request must be specific and in writing; except to the extent we already have used or disclosed your personal health information in reliance on your consent.

I agree to comply with the terms and conditions as outlined on the Patient Registration form.
(You have the right to refuse to sign this acknowledgment if you so choose. With understanding your refusal to sign also terminates care.)

Signature: ____ **Date:** __________________

PATIENT NAME: ________________________________ **ID#:** ________________ **DATE:** ____________

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

1. **Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad, but I can manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain.
(4) Pain medication provides me with little relief from pain.
(5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally, but it increases my pain.
(2) It is painful to take care of myself, and I am slow and careful.
(3) I need help, but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights, but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

4. Walking

(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile.
(2) Pain prevents me from walking more than ½ mile.
(3) Pain prevents me from walking more than ¼ mile.
(4) I can only walk with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 minutes.
(5) Pain prevents me from sitting at all.

6. Standing

(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but, it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

7. Sleeping

(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hour
(5) Pain prevents me from sleeping at all.

8. Social Life

(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

9. Traveling

(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only

Comorbidities:	Cancer	Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
	Diabetes	Obesity
	Heart Condition	Surgery for this Problem
	High Blood Pressure	Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
	Multiple Treatment Areas	

ICD Code: ________________