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: $_____

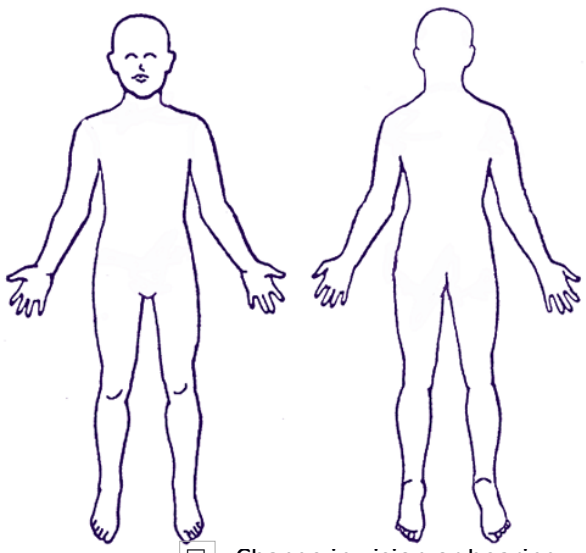
I understand that I am financially responsible for any balance due. **Initial Here: _____**

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.

CONSENT FOR TREATMENT OF A MINOR

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.**

LEFS – INITIAL VISIT

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

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

Therapist Use Only

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

ICD Code: _____