Getting you back in action!

Daniel A. Souza PT, DPT
Craig A. Legacy PT, DPT

PATIENT INFORMATION & BRIEF HISTORY

Patient's Name____ Date____________

Address__________________________ City________________ State_____ Zip________

Phone number______________________ Age________________ Birth Date__________

SS#____________________________ E-Mail Address__________________________

Emergency contact______________________ Phone number____________________

Marital Status______________________ Spouse's Name______________________

Employer____

Address__________________________ City________________ State______ Zip________

Work Phone______________________ Occupation__________________________

Referred to this office by Doctor____

Date of Injury______________________ Date of Surgery______________________

How did this injury occur?____

Have you had previous physical therapy for your present condition for which you to receive treatment here? Yes_______ No_______

If yes, state where____________________ When?____________________________

The above information is correct to the best of my knowledge.

I hereby authorize Rancho Santa Margarita Physical Therapy and Sports Medicine (RSMPT)/San Clemente Orthopaedic Rehabilitation (SCOR) to provide my insurance company with full information regarding treatment rendered, when so requested.

I hereby authorize my insurance company to pay directly to RSMPT/SCOR medical benefits otherwise payable to me, and I will be responsible to RSMPT/SCOR for all expenses incidental to treatment rendered not paid under this plan.

I hereby render my consent for evaluation and treatment of my injury/illness to RSMPT/SCOR.

Patient Signature______________________________(or if minor, Parent/Guardian signature)

Parent/Guardian Name____

Name: ______________________________ **SSN:** ______________ **Date:** __________

Leisure activities, including exercise routines: ______________________________

Occupation, including activities that comprise your workday: ______________________________

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: ______________________________

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ constipation
❑ fever/chills/sweats	❑ muscle weakness	❑ diarrhea
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection	❑ sexually transmitted disease/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ diabetes	❑ tuberculosis
❑ heart problems	❑ stroke	❑ thyroid problems
❑ high blood pressure	❑ depression	❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. ______________ 2. ______________ 3. ______________

What date (roughly) did your present symptoms start? ______________________________

What do you think caused your symptoms? ______________________________

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

Treatment received so far for this problem (chiropractic, injections, etc) ______________________

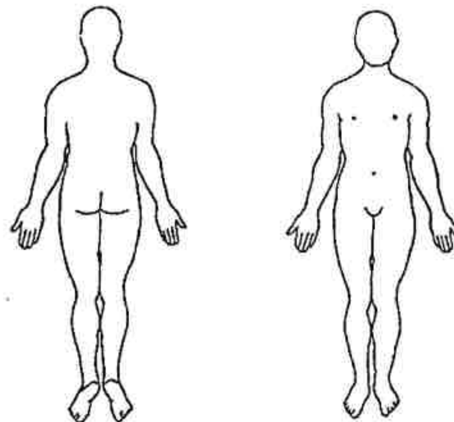
Please list special tests performed for this problem (x-ray, MRI, labs, etc) ______________________

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**__________ **Treatment rec'd**__________

How long did it take for you to feel better? ______________________________

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. ______________________________
2. ______________________________
3. ______________________________

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. ______________________________
2. ______________________________
3. ______________________________

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:__________

The best your pain has been during the past 24 hours: __________

The worst your pain has been during the past 24 hours: __________

Payment Schedule

We believe that a clear definition of our financial policy will allow us to concentrate on the more important issue of **helping you regain and maintain your health**.

AS A COURTESY, INSURANCE BENEFITS WILL BE VERIFIED FOR OUR PATIENT'S PHYSICAL THERAPY, BUT THIS IS NOT A GUARANTEE OF PAYMENT. IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW WHAT HIS/HER INSURANCE WILL COVER FOR PHYSICAL THERAPY

Insurance - The patient is responsible for payment in full until the deductible is met. Once the deductible is met, the patient will be responsible for copayments/coinsurance.

- Co-payments are due at each appointment.
- Coinsurance will be accumulated based on the number of visits and billed to the patient.

Aetna- Aetna only allows one Initial Evaluation every 180 days and one Re-Evaluation every 90 days.

Worker's Compensation - Once we have received authorization, the designated insurance will be billed directly.

Auto Accident - No third party billing will be accepted! The proper insurance will be billed directly.

Medicare - All charges not covered by secondary or supplement insurance are the responsibility of the patient.

Cash Patient - Payment will be collected at each appointment.

- $130.00 for the Initial Evaluation
- $90.00 for each additional treatment

**Any supplies including pillows, tubing, braces, supports, etc. are to be paid for when items are received.

Patients who cancel their appointment within 24 hours of the scheduled time will be charged a $40.00 "no show" fee. However, **please do not come in if you are sick** out of respect for our other patients and staff. Cancellations due to illness will not result in a "no show" fee if you notify us before your scheduled appointment time.

_____ *(initial)* ** I have read and acknowledge the cancellation policy. **

I understand and agree that I am ultimately responsible for all charges regardless of my existing medical coverage.
I also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any and all legal fees/court costs in addition to the outstanding balance.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND RESPONSIBILITIES OF PAYMENT.

SIGNATURE ____ DATE____________________

Daniel A. Souza PT, DPT
Craig A. Legacy PT, DPT

ELECTRICAL STIMULATION/IONTOPHORESIS PADS

Dear Clients:

Due to insurance companies not providing reimbursement for individual patient electrodes for electrical stimulation and/or iontophoresis, we regret that we must charge our patients directly so that we may cover our costs. This ensures that you will have personalized, clean electrodes for your individual use. Each packet for electrical stimulation lasts approximately 15 visits and a new packet will be issued when necessary. A new packet is required for every use of iontophoresis. The fee is $20 for electrical stimulation/iontophoresis pads.

I understand and agree to the above terms.

____________________________ ____________________________

Signature Date

SCOR/RSMPT
PATIENT INFORMATION CONSENT FORM

I have read and fully understand SCOR/RSMPT's Notice of Information Practices. I understand that SCOR/RSMPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provide and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that SCOR/RSMPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in SCOR/RSMPT's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name

____
Signature

____
Date

RSMPT & SCOR use a team approach to patient care. You will be seen by a licensed Physical Therapist on each visit, and under his or her supervision, part of the treatment may be delivered by a PTA (licensed Physical Therapist Assistant), ATC (Athletic Trainer Certified) or PT Aide.

Initials______

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

RSMPT/SCORPT/SCOR'S LEGAL DUTY

RSMPT/SCORPT/SCORPT is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

RSMPT/SCORPT uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, RSMPT/SCORPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you. RSMPT/SCORPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, RSMPT/SCORPT's policy is to obtain your written authorization before disclosing your persona health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

RSMPT/SCORPT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. RSMPT/SCORPT will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that RSMPT/SCORPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed at the top of this page. You may also send a written complaint to the US Department of Health and Human Services. For further information on RSMPT/SCORPT's health information practices or if you have a complaint, please contact us at the address listed below.

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(949) 459-9010
SCOR Physical Therapy
(949) 496-0122
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