Getting you back in action!

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

PATIENT INFORMATION & BRIEF HISTORY

WORKER'S COMPENSATION CLAIM

Patient's Name ______________________ Date __________

Address ______________ City __________ State _____ Zip ________

Home Phone ______________ Age __________ Birth Date __________

SS# ______________ Driver's License # ______________

Marital Status ______________ Spouse's Name ______________

Employer ______________________

Address ______________ City __________ State _____ Zip ________

Work Phone ______________ Supervisor's Name ______________

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 are to receive treatment here? Yes ❑ No ❑

If yes, state where: ______________ When? ______________

____

Do you now have or had any of the following:

Diabetes	Yes ❑	No ❑	Sensitive to heat / ice	Yes ❑	No ❑
High Blood Pressure	Yes ❑	No ❑	Pregnant	Yes ❑	No ❑
Heart Disease	Yes ❑	No ❑	Other Allergies	Yes ❑	No ❑
Heart Attack	Yes ❑	No ❑	Previous Surgery	Yes ❑	No ❑
Pacemaker	Yes ❑	No ❑	Hernia (any)	Yes ❑	No ❑
Headaches	Yes ❑	No ❑	Seizures	Yes ❑	No ❑
Kidney Problems	Yes ❑	No ❑	Metal Implants	Yes ❑	No ❑
Nervous Disorders	Yes ❑	No ❑			

If yes to any of the above, please explain and give approximate dates: ______________

Are you presently taking medications? Yes ❑ No ❑ If yes, please list what medications and for what condition:

____

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

I hereby render my consent for evaluation and treatment of my injury / illness to San Clemente Orthopaedic Rehabilitation.

Patient Signature ______________________

- -

W/C Ins. ______________ Phone # ______________

Address ______________ Fax # ______________

______________ Claim # ______________

Adjustor ______________ Auth. by ______________

Case Manager ______________ Phone # ______________

REHABILITATION & SPORTS MEDICINE

SCOR: 653 Camino De Los Mares #110, San Clemente, CA 92673 (949) 496-0122 Fax (949) 496-5027 www.scorpt.com
RSM: 29803 Santa Margarita Pkwy., Rancho Santa Margarita, CA 92688 (949) 459-9010 Fax (949) 459-9020 www.rsmpt.com

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) ______________________

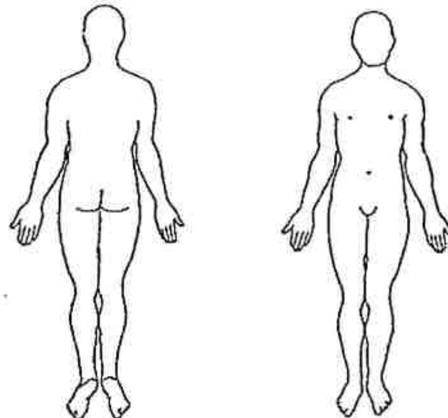
Have you ever had this problem before: ☐ Yes ☐ No When__________ Treatment rec'd__________

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: __________

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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.

- $95.00 for the Initial Evaluation
- $75.00 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__________________

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NON-CONPLIANCE NOTIFICATION

It is the experience of our office that employees presenting legitimate work related injuries do not miss scheduled physical therapy appointments. Their focus is on getting well, complying with prescribed treatment, and returning safely to the work place as soon as possible. Any patient that is not-compliant with their treatment in our office will be brought to your immediate attention.

This letter is to notify you that:

Name:____________________________________

Employer:__________________________________

Date of Injury:_______________ **S.S.#**____________

Insurance Carrier:____________________________

Patient has missed appointments for one of the following:

Physical/Occupational Therapy Appointment
Dates missed or cancelled:______________________

____

SCOR and RSMPT are committed to excellence in patient care and dedicated to the rehabilitation of our Workers Compensation Patients. If you have any questions or concerns regarding this patient, please do not hesitate to contact our office.

Patient Initials:__________

You have been informed that this letter will go to Your insurance carrier on all cancelled and "no show" appointments unless you reschedule that appointment the same week.

PHYSICAL THERAPY PRESCRIPTION:

________**x a week for** __________ **weeks.**

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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

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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

SCOR/RSMPT'S LEGAL DUTY

SCOR/RSMPT 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

SCOR/RSMPT 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, SCOR/RSMPT 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. SCOR/RSMPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, SCOR/RSMPT'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.

SCOR/RSMPT 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. SCOR/RSMPT 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 SCOR/RSMPT 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 SCOR/RSMPT's health information practices or if you have a complaint, please contact us at the address listed above.

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