Power Physical Therapy and Sports Medicine

3140 Red Hill Ave, Suite 225 Costa Mesa, CA (714) 557-2100

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	☐ Married ☐ Single ☐ Other
S.S. #: - -			
Home Phone: ( ) -	Cell Phone: ( ) -	Spouse's Name:	
Email:			

WORK INFORMATION

Employer:	Work Phone: ( )	Occupation:	
Employer Address:	City:	State:	Zip:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ F/T Student ☐ P/T Student ☐ Not Employed

REFERRAL/PHYSICIAN INFORMATION

Chose clinic because: ☐ Former Patient ☐ Physician ☐ Close to Work/Home ☐ Website ☐ Insurance Plan ☐ Family/Friend

Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP:	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACK UP)

Insurance Name: ☐ Auto: ☐ Labor & Industries:

Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City:	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION

Name:	Law Firm:	Phone: ( ) -	
Address	City:	State:	Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to **Power Physical Therapy and Sports Medicine, Inc.** I understand that I am financially responsible for any balance. I also authorize Power Physical Therapy and Sports Medicine, Inc. to release any information required to process my claims.

PATIENT/ GUARDIAN SIGNATURE DATE

Power Physical Therapy and Sports Medicine, Inc.

MEDICAL HISTORY FORM

Name:_____ DOB:_____ Date:_____

Occupation including activities that comprise your workday:_____

Leisure activities, including exercise routines:_____

Are you on a work restriction from your doctor? YES NO Are you latex sensitive? 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/sweat	☐ Muscle weakness	☐ Diarrhea
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath
☐ Weight loss/gain	☐ Heartburn/indigestion	☐ Fainting
☐ Falls	☐ Difficulty swallowing	☐ Cough
☐ Difficulty maintaining balance while walking	☐ 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	☐ Multiple sclerosis
☐ High blood pressure	☐ Asthma	☐ Epilepsy
☐ Circulation problems	☐ Rheumatoid arthritis	☐ Eye problem/infection
☐ Blood clots	☐ Other arthritic condition	☐ Ulcers
☐ Stroke	☐ Osteoporosis	☐ Liver problems
☐ Anemia	☐ Kidney problems/infection	☐ Hepatitis
☐ Bone or joint infection	☐ Pelvic inflammatory disease	☐ pneumonia
☐ Chemical dependency (i.e. alcoholism)	☐ Sexually transmitted disease/HIV	☐ Bladder/urinary tract infection

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 (prescribed or over-the-counter) 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 medication for any medical conditions? **YES NO**

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

1._____ 2._____ 3._____

Power Physical Therapy and Sports Medicine, Inc.

MEDICAL HISTORY FORM (CONTINUED)

Name:_____ DOB:_____ Date:_____

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)_____

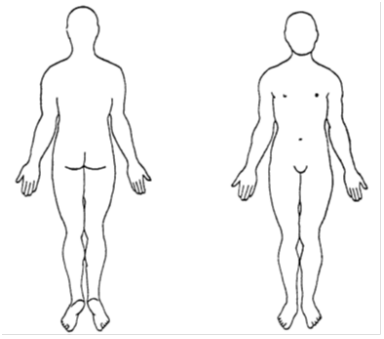
Have you ever had this problem before: YES NO When_____ Treatment Rec'd_____

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

BODY CHART

Please mark on the chart below the areas where you feel symptoms. Use the following symbols:

Shooting/sharp pain O Dull/aching pain III Numbness = Tingling



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

---

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 on with medication

When are your symptoms worst? [ ] Morning [ ] Afternoon [ ] Evening [ ] Night [ ] After exercise

When are your symptoms best? [ ] Morning [ ] Afternoon [ ] Evening [ ] Night [ ] After exercise

---

Using the 0 to 10 scale, with 0 being "*no pain*" and 10 being the "*worse 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:_____

PT Initials _____

This medical information is correct to the best of my knowledge. _____

Signature of Patient ***Date***

Power Physical Therapy and Sports Medicine, Inc.

OFFICE POLICY

(Effective May 08, 2017)

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hearby agree and give my consent for **Power Physical Therapy and Sports Medicine, Inc.** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNEMENT OF INSURANCE BENEFITS: I hereby authorize **Power Physical Therapy and Sports Medicine, Inc.** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. **Co-payments must be made at the time services are rendered**. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Estimated patient payment/ co-pay/ deductible amount per visit $_____

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize Power Physical Therapy and Sports Medicine, Inc. to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature:_____ Date_____

The above information has been read and/or explained to me. **I UNDERSTAND ULTIMATELY IT IS MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Clinic Representative Signature **Date**

Power Physical Therapy and Sports Medicine, Inc.

OFFICE CANCELLATION/NO SHOW POLICY

(Effective May 08, 2017)

CANCELLATION & NO-SHOW POLICY: The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make a difference between whether you succeed in your treatment goals or not. Usually your referring doctor and/or your therapist have prescribed a frequency of PT visits that is ideal for the treatment of your individual condition. Showing up as scheduled for these visits is critical for your successful recovery.

We require **24 hours of notice** in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you complete the full prescribed number of treatments that week. In some cases, this may not work since some forms of treatment do not work well if given two sequential days.

There is **a $35.00 charge** for a cancellation without a proper 24-hour notice. This charge is not reimbursable by insurance but will have to be paid by you personally. This fee will be charged to your account on the same day as the missed appointment.

If a patient does not show for an arranged session without letting us know, the session is charged **at $75.00.** This charge is not reimbursable by insurance but will have to be paid by you personally. This fee will be charged to your account on the same day as the missed appointment.

If a patient is more than **15 minutes late** for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for a session. *If a patient late cancels or no-shows more than three times, the patient is responsible for the full charge of the visit and the rest of his/her scheduled visits will be removed.*

Worker's Compensation and Personal Injury patients: documentation of a missed appointment is forwarded to your Case Manager and Primary Care Physician which may jeopardize your claim.

Things to Consider: Please understand that your pain will probably increase and decrease as your rehabilitation program progresses until it is eradicated. Either condition can seem to be reason not to come in:

a) You're feeling worse and think the treatment is not working.
b) You're feeling better and it's a great day for wind-surfing.

Neither of these conditions is legitimate as a reason not to come in because:

a) If you're in pain, come in for treatment and communicate your pain with the therapist.
b) If you're not in pain, now is the time that we can begin doing correctional therapy to improve the underlying causes of your problem and provide education for injury-prevention purposes in your future.

When you don't show as scheduled, **three people** are negatively affected:
1) You, because you don't get the treatment you need as prescribed by the doctor and/or PT.
2) The therapist who now has the space in their schedule since the time was reserved for you personally.
3) Another patient who could have been scheduled for treatment if you had given proper notice.

_____ _____

Patient/Guardian/Responsible Party Signature **Date**

_____ _____

Clinic Representative Signature **Date**

Per the policies described herein, we ask that you authorize us to automatically charge your portion of the bill to your Visa, MasterCard, Discover or American Express. I hereby authorize Power Physical Therapy & Sports Medicine to apply the $35.00 or $75.00 cancel/no-show fee to my account.

Visa ___ MasterCard ___ American Express___ Discover___

Account Number:_____ Expires: _____/_____ Security Code: _____

Cardholder's Signature:_____ Date:_____

Power Physical Therapy and Sports Medicine, Inc.

NOTICE OF PRIVACY PRACTICES

(Effective September 15, 2011)

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.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care, or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about your for workers' compensation or similar programs. **For Public Health Risks:** We may dislose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and request a copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosure:** You have the right to request in writing, a list accounting for any disclosures of yoru medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. ***We are not required to agree to your request.*** **Your right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

_____

_____

Patient or Personal Representative Signature **Date**

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

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

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____