

Patient Summary Form

PSF-750 (Rev.2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.
*Fax number may vary by plan.

Patient Information

Female
 Male

Patient name: Last [] First [] MI [] Patient date of birth: [] [] []

Patient address: [] City: [] State: [] Zip code: []

Patient insurance ID#: [] Health plan: [] Group number: []

Referring physician (if applicable): [] Date referral issued (if applicable): [] Referral number (if applicable): []

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) [] 2. Federal tax ID(TIN) of entity in box #1 []

[] 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other

3. Name and credentials of the individual performing the service(s) []

4. Alternate name (if any) of entity in box #1 [] 5. NPI of entity in box #1 [] 6. Phone number []

7. Address of the billing provider or facility indicated in box #1 [] 8. City [] 9. State [] 10. Zip code []

Provider Completes This Section:

Date you want **THIS** submission to begin:

[] [] []

Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

Date of Surgery

[] [] []

Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° [] [] [] [] [] []

2° [] [] [] [] [] []

3° [] [] [] [] [] []

4° [] [] [] [] [] []

Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

98940 98942
 98941 98943

Current Functional Measure Score

Neck Index [] DASH [] [] []
 Back Index [] LEFS [] (other) []

Patient Completes This Section:

Symptoms began on:

[] [] []

(Please fill in selections completely)

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
 Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

- 1 Constantly (76%-100% of the time)
- 2 Frequently (51%-75% of the time)
- 3 Occasionally (26% - 50% of the time)
- 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

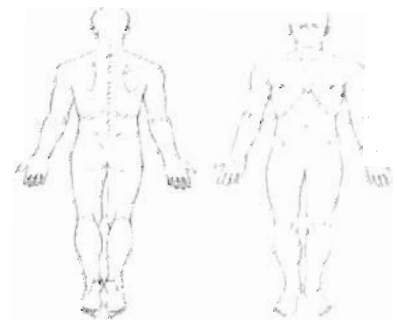
6. How is your condition changing, since care began at **this** facility?

- 0 N/A — This is the initial visit
- 1 Much worse
- 2 Worse
- 3 A little worse
- 4 No change
- 5 A little better
- 6 Better
- 7 Much better

7. In general, would you say your overall health right now is...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X _____

Date: _____

Back Index

ACN Group, Inc. Form BI-100

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

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back 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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

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

Back
Index
Score

PRINT CLEARLY

Name(first) _____ (last) _____ (m.i) _____

Home Address _____

City _____ State _____ Zip _____

Hm Phone _____ Wk phone _____

Social Security _____ Birthdate _____ Age _____ Sex: M / F

Drivers Lic # _____ Email Address _____

Emergency Contact _____ Telephone _____

Doctor _____ Telephone _____

Address _____ UPIN # _____

Who may we thank for your referral other than your Doctor? _____

Employer _____ **Employment** Full - Pt-time - not currently working - Retired

Address _____ Phone _____

Relation Married - Single - Divorced - Separated - Widowed **Student** No - Full-time - Part-time

Injury Type work auto home other _____ **Injury Date** _____

Area(s) being Treated: _____

Claim / Authorization / Referral # _____ Lawyer involved Yes / No

Attorney name _____ Telephone # _____

Address _____

Primary Insurance _____

Subscriber Social Security # _____ Date-of-Birth _____

Secondary Insurance _____

Subscriber Social Security # _____ Date-of-Birth _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize **Orthopaedic & Spine Care Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY

Financial Class: W/C PRVT MC CASH LIEN

Therapist: 1-Shaw 3-Davis 4-Bartlett 5-Macias 6-Andrews 7-Esparza
8-Ferdig 9-Maurer 12-Sulimoff 13-Worah 14-Takiguchi 15-Caringal

OSCPT

MEDICAL HISTORY

Patient Name _____ Age _____

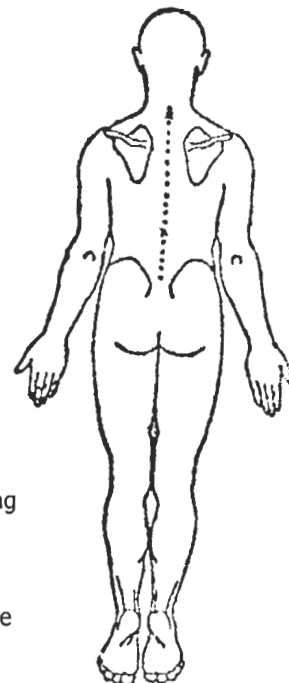
Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition _____



Have you recently noted:

- Weight loss /gain
- Weakness
- Pregnant / IUD
- Nausea / Vomiting
- Fever / chills / sweats
- Fatigue
- Numbness / Tingling

Have you EVER been diagnosed as having any of the following?

- Cancer
- Circulation problems, clots
- Chemical dependency, alcoholism
- Multiple sclerosis
- Ulcer
- Stroke
- Heart problems, Murmur
- Asthma, Breathing Problems
- Thyroid problems
- Rheumatoid arthritis
- Hernia
- Epilepsy, seizures
- High Blood Pressure
- Lung disease
- Diabetes
- Other arthritic conditions
- Depression
- Pacemaker/ Metal Implant

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

- Headaches
- Abdominal Pain
- Change in Vision or Hearing
- Urinary Problems/Infections
- Unusual Shortness of Breath
- Pain at night
- Indigestion/Heartburn
- Injured Motor Vehicle Accident
- Repetitive Nausea, Vomiting
- Dizziness
- Long Standing Constipation
- Releasing Urine (coughing or sneezing)
- Easy Bruising/Bleeding
- Cramps in Legs when walking
- Fainting
- Any previous injury that may affect current care
- Neck Swelling/Lumps
- Recurrent Diarrhea
- Trouble Swallowing
- Hurried Need to Urinate
- Leg/Ankle swelling
- Insomnia
- Allergies / Skin sensitivity

Explain & give approximate dates for any items indicated above _____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type of pain: sharp / burning / aching / tingling / numbness / other _____

Does pain radiate to arms and / or legs _____

Rate your pain (average) on a 1-10 scale (1=minimal 10=severe) _____

Is there anything else you would like to include? _____

Patient Signature _____ **Date** _____

Therapist Use Only Below

Baselines: Blood Pressure _____
Pulse _____
Respiration _____

Therapist Signature _____ **Date** _____

CANCELLATION & NO-SHOW POLICY

We take treatment cancellations seriously at **Orthopaedic & Spine Care Physical Therapy** because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Working together we can help you achieve your goals in treatment.

We require 24 hours notice in the event of a cancellation.

It is your responsibility, when you call in; to have an alternative time in mind to insure that you will receive your full prescribed number of treatments that week. Cancellations may make it necessary for you to receive a treatment by one of our therapists, other than the one you originally scheduled with.

There is a \$25 charge for cancellation without proper notice (24 hours).

This charge will not be covered by insurance, but will have to be paid by you personally.

Please understand that your pain will probably vary during your course of treatment. Some conditions can seem to be a reason not to come in: whether your feeling better or worse. It is important to come in and work with the Therapist to re-assess and treat you; and possibly progress your program.

When a patient doesn't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or physical therapist; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will do our best to have you back to full function swiftly. We're looking forward to working with you.

I have read this document and fully understand my responsibilities.

Patient Signature

Date

**Orthopaedic and Spine Care Physical Therapy
PATIENT INFORMATION CONSENT FORM**

I have read and fully understand *Orthopaedic and Spine Care Physical Therapy's (OSCPT)* Notice of Information Practices. I understand that *OSCPT* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided 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 *OSCPT* 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 *OSCPT'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

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*Is it acceptable to leave a message for you at: Home Workplace Cell Phone Pager
(Circle any that you approve)*

Patient Name

Patient Signature

Date

OSCPT

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 hereby agree and give my consent for **Orthopaedic & Spine Care Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

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 may 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. We have reviewed these benefits with you and you agree to pay your balance remaining after your insurance carrier has paid its portion of this bill.

WORKERS' COMPENSATION POLICY

If you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

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

Arrangements for payment of patient's co-pay/deductible (**circle one**):

Will pay each visit

Will pay weekly in advance

Authorized for monthly statement

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date

NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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 DISCLOSURE 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 you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose 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 copy of 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 Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your 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