

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

	Activities	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, homework, 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
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____ / 80

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, *The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application*, *Physical Therapy*, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

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 _____

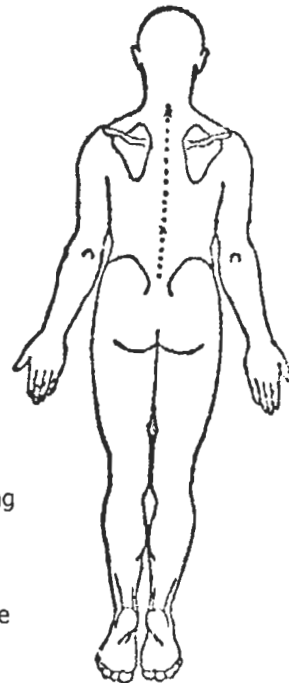
Type of Injury / Condition _____

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