

PATIENT INFORMATION

ACCT# _____

SOCIAL SECURITY # _____

DRIVER'S LICENSE# _____

 MARRIED SINGLE WIDOW DIVORCED

 NAME _____ BIRTHDATE ____ - ____ - ____ AGE ____ SEX ____
Last First MI

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE HOME() _____ MOBILE() _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE () _____ EMAIL: _____

 EMERGENCY CONTACT _____ PHONE() _____
Last First MI
REFERRING PHYSICIAN

LAST SEEN MD ____ - ____ - ____ UPIN _____ NPI _____

REFERRING PHYSICIAN _____ PHONE() _____

DIAGNOSIS _____ ICD 9 CODE _____ DOI ____ - ____ - ____

Do you currently or have you in the past 6 months had home healthcare services? Yes NoHave you been hospitalized in the past 60 days? Yes No

If yes to either question, who is your home health provider? _____

What is the discharge date for your hospitalization/home healthcare services? _____

MEDICAL INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD(S)
Please provide Name of Insured and Birthdate for all plans.

 SELF PRIVATE AUTO LIEN MEDICARE WORK COMP OTHER _____

INSURANCE _____ GROUP# _____ ID# _____

NAME OF INSURED _____ BIRTHDATE ____ / ____ / ____ SEX _____

WORKERS' COMPENSATION INFORMATION

DOI ____ - ____ - ____

ADJUSTOR _____ CLAIM# _____ PHONE() _____

AUTHORIZED BY _____ DATE _____ DURATION _____

ATTORNEY _____ ADDRESS _____ PHONE() _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY
 NAME _____ SOCIAL SECURITY # _____
Last First MI

RELATIONSHIP TO THE PATIENT _____ BIRTHDATE ____ / ____ / ____ SEX _____

ADDRESS _____ HOME PHONE () _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE () _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider of medical services and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to CENTRAL COAST PHYSICAL THERAPY and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize CCPT to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____



Central Coast Physical Therapy

PAST MEDICAL HISTORY:

Please circle any condition that you currently have or have had in the past:

High blood pressure	Stroke	Arthritis
Lung Disease/Problems	Cancer	Kidney Disease
Heart Disease/Problems	Diabetes	Liver Disease
Asthma/Allergies	Pacemaker	Angina
Circulation/Bleeding Problems	Osteoporosis	Fibromyalgia

Are you allergic to latex? YES NO
 Do you Smoke? YES NO
 Are you Pregnant? YES NO

During the past month have you often been bothered by feeling down, depressed, or hopeless? YES NO
 During the past month have you often been bothered by little interest or pleasure in doing things? YES NO

Are you currently taking any medications? YES NO

If yes, please list ALL medications you are currently taking:

Please list past surgeries and dates:

Please list any medical conditions you have that have not been documented above:

What are your physical therapy and/or fitness goals?:

Patient signature: _____ Date: _____



Central Coast Physical Therapy

Medical Screening Form

Name _____ Date: _____

CURRENT CONDITION:

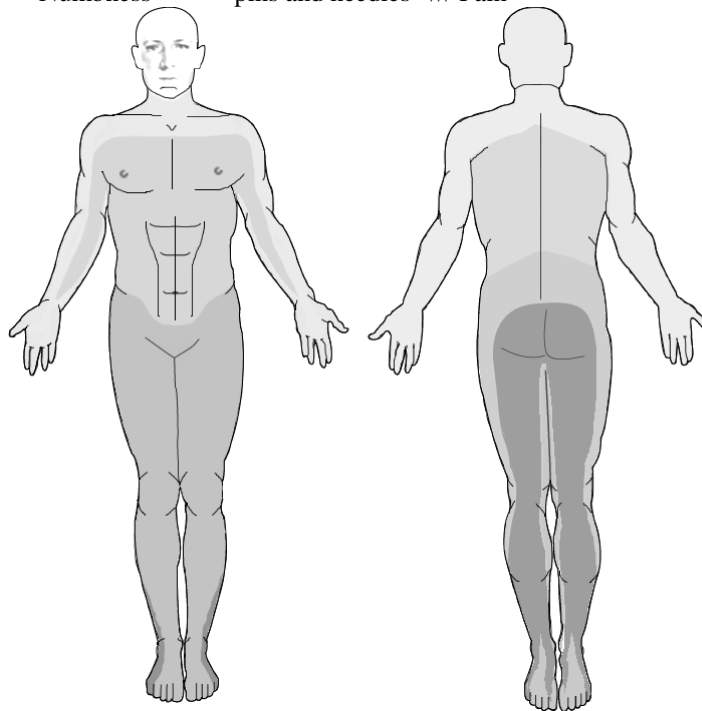
When did these symptoms start? _____

How did the injury occur?: (gradually, suddenly, injury): _____

My symptoms are currently: getting better / about the same / getting worse
Please list any previous treatment for the condition we are seeing you for today: _____

Have you ever had this problem before? YES NO
If so how was the problem treated? _____

Have you had any imaging studies done for this problem (x-rays, MRI, etc.) YES NO
Please use the following symbols: ^^ Numbness *** pins and needles /// Pain



Rate your pain (1=mild, 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 At its best: 1 2 3 4 5 6 7 8 9 10
Right now: 1 2 3 4 5 6 7 8 9 10

Currently I am experiencing the following (circle all that apply): dizziness
Unexplained weight loss difficulty swallowing changes in bowel or bladder function
Increased pain at night headaches depression
Fever/chills/sweats nausea/vomiting shortness of breath
Changes in appetite numbness or tingling poor balance/falls



Central Coast Physical Therapy

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OFFICE POLICY

Consent To Treatment: I the undersigned agree to give my consent to Central Coast Physical Therapy to furnish physical therapy care and treatment services. These services include but are not limited to therapeutic test/s, treatments or procedures, manipulation, stretching, or exercise as directed under the general instructions of the Physical Therapist, Physical Therapist Assistant, or Physical Therapy Aide. I authorize my Physical Therapist(s) to take photographs relating to my physical condition as are deemed necessary.

Consent for treatment of a Minor: As parent and/or legal guardian, I authorize Central Coast Physical Therapy to treat _____ (minors name) while I am not present.

Assignment of Insurance Benefits: I hereby authorize Central Coast Physical Therapy 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 compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Cancellation and No-Show Policy: Central Coast Physical Therapy requires a 24 hour notice in the event of a cancellation. The charge for cancellation or no-show without proper notice is \$25. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

Co-Payments: Co-payments may be paid at the time of service. If your co-payment is not paid at the time of service you will be billed for your contracted co-payment.

Non-Sufficient Funds: Checks returned for non-sufficient funds may be subject to a \$25 processing fee.

Patient/Guardian/Responsible Party Signature

Date

Print Name

Financial Policy: We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Central Coast Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. If formal collections procedures become necessary you will be responsible for additional costs incurred. Furthermore, I understand that I cannot change my chosen payment option after services have been rendered .

I choose to self-pay at a discounted cash rate. I further understand that no insurance company will be billed and that I cannot change from this option during my course of treatment. _____(please initial).

I choose to have Central Coast Physical Therapy bill my insurance company. It is my responsibility to understand my physical therapy benefits and coverage. _____(please initial).

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

Patient/Guardian/Responsible Party 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