ProActive PHYSICAL THERAPY

Patient Information

Please print clearly and complete all sections. If you have any questions, please ask the receptionist.

Patient Name: _____ (Last / First / MI) Date: _____

Date of Birth: _____ Age: _____ Sex: Male: ❑ Female: ❑

Address: _____ (Street / City / State / Zip)

Phone Number: ( ) - _____ (Primary) ( ) - _____ (Secondary)

Parent/Guardian: If patient is a minor _____ (Name) _____ (Relationship to patient)

Emergency Contact: _____ (Name) _____ (Phone Number)

Referring Provider: _____ (Name) _____ (Practice Name and/or City & State)

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID/Member #: _____ ID/Member #: _____

Group#: _____ Group#: _____

If patient is not the plan subscriber, please complete below

Subscriber Name: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Relationship to patient: _____ Relationship to patient: _____

Claim Information

Worker's Compensation or Motor Vehicle Accident Only

Worker's Compensation

Employer: _____

Employer Address: _____

Date of Injury: _____

Claim Number: _____

Claims Manger: _____

Have you had any previous physical therapy visits on this claim? Yes❑ No❑

Motor Vehicle Accident

Insurance: _____

Claim # _____

Date of Injury: _____

Claim Address: _____

Claims Adjuster: _____

Phone Number: _____

Who can we thank for telling you about ProActive Physical Therapy? _____

ProActive PHYSICAL THERAPY

Name: _____ **Height:** _____ **Weight:** _____ D.O.B.____/_____/_____

Date of Onset of Pain: _____ **Date of Injury:** _____ **Date of Surgery:** _____ ☐ New Injury ☐ Chronic

Pain Location: _____ **Treatment Side:** ☐ N/A ☐ Left ☐ Right

Primary Physician/Referring Doctor: _____

Pain Scale: 0= None 5= Moderate 10= Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aggravating Factors: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down/Sleeping ☐ Stairs

☐ Reaching ☐ Lifting ☐ Getting up from a chair ☐ Bending forward ☐ Carrying heavy objects

Have you experienced any of the following: ☐ Numbness ☐ Tingling ☐ Increased Pain at Night

☐ Pain with Coughing/Sneezing ☐ Dizziness ☐ Nausea ☐ Loss of bowel/bladder control

What makes it feel better? _____ **Feel worse?** _____

History of Similar Symptoms: ☐ No ☐ Yes **History of Falls in last year:** ☐ No ☐ Yes

Home Health Care: ☐ No ☐ Yes **Hospitalization in last 3 months?** ☐ No ☐ Yes

Occupation: _____

Medical History:

☐ Alzheimer's	☐ Fracture or Suspected Fracture	☐ Rheumatoid Arthritis
☐ Cardiovascular Disease	☐ High Blood Pressure	☐ Traumatic Brain Injury
☐ Cauda Equina Syndrome	☐ History of Cancer	☐ Allergies: _____
☐ CVA / Stroke	☐ Huntington's	☐ Unexplained Weight Loss
☐ Current Infection	☐ Immunosuppression	☐ Pacemaker
☐ Diabetes Mellitus Type 1	☐ Lupus	☐ Pregnant
☐ Diabetes Mellitus Type 2	☐ Muscle Dystrophy	☐ Seizures
☐ Hemophilia	☐ Osteoarthritis	☐ HIV/AIDS
	☐ Hepatitis B/C	☐ Other: _____

Diagnostics: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Diagnostic Ultrasound

Results of Imaging: _____

Medications: ☐ See attached _____

_____

Patient Goals for Physical Therapy:

_____

Patient Signature _____ **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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ 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

ProActive
PHYSICAL THERAPY

Statement of Privacy Practices

We at ProActive SportsMed are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices, but we will always inform you of any changes that might affect your rights.

Protecting Your Personal Health Care Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Washington. This includes issues relating to your treatment, payment, and our physical therapy operations. Your personal health information will never be otherwise given to anyone-even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone that you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access, and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices all to all former, current, and future patients. Therefore, you can be confident that your protected health care information will never be improperly disclosed or released.

Collecting Protected Health Care Information

We will only request personal information needed to provide our standard of physical therapy care, implement payment activities, conduct normal physical therapy operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information for third parties if deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Care Information

As stated above, we may disclose information as required by law. We are obligated, under certain circumstances, to provide information to law enforcement and government officials. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments. This would include voicemail messages, answering machines, e-mail or text message reminders, and phone calls.

Patient Rights

You have a right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. A full, detailed copy of our privacy practices and your rights are available upon request and are posted in our front office.

ProActive
PHYSICAL THERAPY

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of ProActive SportsMed. ProActive Sportsmed reserves the right to change the privacy practices that are described in the Statement of Privacy Practices . If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the first available opportunity. I may also request a revised statement be mailed to me.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____

Your Protected Health Information Designees

If you are not available when we attempt to contact you, please list below those individuals with whom we can leave a message or briefly discuss your medical information (e.g. appointments, payment information, etc.).
This person will also be able to call the office on your behalf.

Please print the name and relationship (to the patient) of each designee below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

❑ Check here if you **do not want** your health care information discussed with anyone but yourself.

Record of Acknowledgement Not Obtained

For Office Use Only

We attempted to obtain written acknowledgement of patient's receipt of our Statement of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

- ❑ Patient needed more time to review the Statement of Privacy Practices
- ❑ Patient wanted to consult with another person befire signing
- ❑ Patient refused to sign
- ❑ Patient is unable to sign
- ❑ Other (explain) _____

Was prior treatment provided? ❑ Yes ❑ No

Date any prior treatment was provided: _____

Employee Signature: Date:

ProActive
PHYSICAL THERAPY

Financial Policy

We'd like to thank you for choosing ProActive Sportsmed for your physical therapy treatment.
In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined percentage of our treatment charge. We therefore request that on each visit you pay the difference and/or any applicable co-payments. This will enable you to keep your account current and avoid a large balance that may be difficult for you to pay in one payment at the end of your treatment.
All accounts not covered by insurance are due and payable in full at the time of service. We accept cash, checks, and credit/debit cards. If needed, you may apply for an extended payment plan upon approval of credit.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim. However, we can and will help by submitting your claim for you. The balance for services rendered at ProActive SportsMed is your financial responsibility.

I have read and understand: _____ Initials

Late Cancellations and No-Shows

We understand that sometimes the unexpected can happen, and you may be unable to keep and appointment. We would appreciate 24 hours notice prior to a scheduled appointment if you need to cancel or reschedule. If a patient fails to appear without contacting us for three scheduled appointments, or cancels and excessive number of times, physical therapy treatment may be discontinued and the referring provider notified.

I have read and understand: _____ Initials

I authorize my insurance benefits to be paid directly to ProActive SportsMed and I understand that I am financially responsible for any balance due. I also authorize the release of any medical information necessary to process this claim.
I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending worker's compensation claims. I understand the parent or guardian accompanying a minor for treatment will be responsible for payment.

I understand that in some instances the applicable insurance does not cover the entire charge. I agree to be responsible for any portion of the bill not covered by insurance. I understand that if my account has an outstanding balance over 90 days duration, I will be charged a 1% per month finance charge unless other arrangements are made in writing with ProActive SportsMed.
I hereby consent to the performance of physical therapy measures prescribed by my referring provider. I hereby waive and release ProActive SportsMed, their agents or employees from any and all claims, costs, expenses, liabilities, or judgments including attorney's fees and court costs (herein collectively "claims") arising out of my/my dependent's participation in the ProActive SportsMed's treatment or any illness or injury resulting therefrom.

I further agree to indemnify and hold harmless ProActive SportsMed, their agents or employees from and against any and such claims except claims caused by gross neglect or willful misconduct.

If a patient is a minor, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by ProActive SportsMed to administer emergency care.

I acknowledge that I have read and understand the financial policy and the cancellation and no-show policy stated above. I certify that all information I have provided in this registration form is true and correct to the best of my knowledge.

_____ Signature of Patient or Responsible Party

_____ Date