PRN PHYSICAL THERAPY **PATIENT INFORMATION**

Cal Rehab & Sports Therapy

OFFICE ____________ TREATMENT START DATE__________________ THERAPIST______________________

NAME ____ SOCIAL SECURITY#______________________________
ADDRESS _______________________________ CITY_______________________STATE_______ZIP __________
HOME PHONE__________________________ WORK PHONE_______________________ EXT________________
DATE OF BIRTH ______________________ AGE____________ DRIVER LICENSE # _______________________

EMPLOYER NAME____
OCCUPATION/POSITION____
PERSON TO CONTACT IN CASE OF EMERGENCY ____
RELATIONSHIP _______________________ PHONE ____

REFERING PHYSICIAN ___________________________ DIAGNOSIS _____________________ICD#___________
ADDRESS ____ PHONE_____________________________

NAME OF INSURED/POLICY HOLDER
NAME_______________________RELATIONSHIP TO PATIENT__________SOCIAL SECURITY #____________
ADDRESS ______________________________CITY______________________STATE________ZIP____________
EMPLOYER NAME____PHONE____________________________

INSURANCE INFORMATION

PVT		WC		MEDICARE		AUTO		LIEN		CASH		HMO		PTPN		OTHER	

PRIMARY
NAME OF INSURANCE COMPANY____
ADDRESS_________________________________CITY_______________________STATE_______ZIP___________
PHONE______________CLAIMS ADJUSTER________________ANY LIMITATION TO TREATMENT_________
POLICY/ID#________________GROUP/CLAIM#______________CERTIFICATION/AUTH#___________________
DATE OF INJURY________________________MEDICAL NECESSITY___________________________________
EFFECTIVE DATE OF INSURANCECOVERAGE__________DEDUCTIBLE_______MET?____COPAY______
BENEFITS_______% TO PAY OUT OF POCKET______________PLAN LIMITATIONS___________________
AUTHORIZED BY_____________________________DATE______________# OF VISITS AUTHORIZED_______

SECONDARY
NAME OF INSURANCE COMPANY ____
ADDRESS________________________________CITY_______________________STATE_______ZIP___________
PHONE__________________ Policy ID #______________________Group Claim # __________________________

I hereby give lifetime authorization for payment or insurance benefits to be made directly to PRN Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to the above name healthcare provider.

I consent to have PRN and/or its' affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

____ ____
SIGNED DATE

To our valued patients:

Please help us make your treatment as effective and consistent as possible. The following parameters pertain to your insurance company.

MEDICARE PATIENTS:

Medicare requires that patients "be seen" by their physician in order to obtain a new prescription every 30 days to continue their physical therapy. Due to Medicare guidelines, your prescription begins on the date it was written, not on the day you start physical therapy treatment.

PRIVATE INSURANCE:

In order for your insurance company to be responsible for physical therapy treatment, they require that you have an updated prescription. Your prescription **begins on the date it was written by your physician, not on the day you begin physical therapy treatment.**
Insurance companies will not pay for the number of treatments that are beyond the prescribed **time limit from the initial prescription.

We bill your insurance company as a courtesy to you. The benefits you have received are only a summary of coverage and not a promise to pay. **You are ultimately responsible for the verification of your insurance benefits and limitations.**

Thank you for your cooperation.

Signature: ____ Date: ____________________

PATIENT MEDICAL HISTORY

PATIENT'S NAME: ______________________________ **DATE:** ________________________

Please circle all that apply to you:

Diabetes	Yes	No	Sensitivity to Heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to Ice	Yes	No
Heart Disease	Yes	No	Allergies	Yes	No
Heart Attack (Myocardial Infarction)	Yes	No	Headaches	Yes	No
Previous Surgery	Yes	No	Seizures	Yes	No
Pacemaker	Yes	No	Hernia	Yes	No
Cancer	Yes	No	Kidney Problems	Yes	No
Metal Implants	Yes	No	Stents, Artery Bypass	Yes	No
Valvular Disease	Yes	No	Coronary Artery Bypass Graft	Yes	No
Arrhythmia	Yes	No	Osteoporosis	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No			
Angioplasty	Yes	No			

Lung Disease

Chronic Obstructive Pulmonary Disease (COPD)	Yes	No	Asthma	Yes	No
Emphysema	Yes	No	Recent Pneumonia	Yes	No
Chronic Bronchitis	Yes	No			

Vascular Disease

Peripheral Arterial Disease	Yes	No	Stroke/TIA	Yes	No
Acquired Respiratory Distress Syndrome (ARDS)	Yes	No	Hypertension	Yes	No
Taking Blood Pressure Meds	Yes	No	Atherosclerotic Disease	Yes	No

General Medical Conditions

Arthritis (Rheumatoid/Osteoarthritis)	Yes	No	Depression	Yes	No
Bladder, Prostrate or Urination Problems	Yes	No	Previous Accidents	Yes	No
Neurological Disease (such as MS or Parkinson's)	Yes	No	Incontinence	Yes	No
Anxiety or Panic Disorders	Yes	No	Sleepy Dysfunction	Yes	No
Gastrointestinal Disease (Ulcer, Hernia, Reflux, Bowel, Liver, Gall Bladder)	Yes	No	Smoker (# of Packs/Day) ______	Yes	No
Visual Impairment (such as Cataracts, Glaucoma, Macular Degeneration)	Yes	No	Alcohol/Drug Addiction	Yes	No
			Prosthesis/Implants	Yes	No
Back Pain (Neck Pain, Low Back Pain, Degenerative Disc Disease, Spinal Stenosis)	Yes	No	Cancer	Yes	No
Hearing Impairment (very hard of hearing with hearing aids)	Yes	No			

Please list any medications being taken:

____

____

____

Other Disorders: ____

____

PATIENT'S NAME: _______________________________ DATE: ___________

When and how did your pain begin? (Please explain): ____________________________

What are your goals for physical therapy? _____________________________________

Female patients only: Are you pregnant? Yes or No

How did you hear about California Rehabilitation & Sports Therapy? (Check all that apply):

__ Family/Friend (Name): _____________
__ Other (Please name): ______________
__ Insurance Company Referral
__ Yellow Pages
__ Physician Referral

When are you scheduled to see your physician next? ______________________

PAIN DESCRIPTION CHART

On a scale of "0 to 10", where "0" represents no pain and "10" represents excruciating pain, please circle where your pain is during the following times:

	No Pain	Excruciating Pain
Least amount of pain this week:	0 ……………………..	10
Most pain this week:	0 ……………………..	10
Pain level at this moment:	0 ……………………..	10

BODY CHART

Please mark on the body below, the symbols that represent your symptoms.
Symbols: Mark ∆ for numbness / Mark O for weakness / Mark X for pain