

PATIENT INFORMATION

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Name: _____ Date: _____

Address: _____
Street Address/P.O. Box City State Zip

Home Phone #: _____ Work Phone #: _____ E-mail Address: _____

Male Female Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ SSN: _____

Marital Status: Single Married Divorced Widowed Separated Children: # of _____

Education: # of years completed: _____ Full-time student Part-time student Non-student

Employed: Full-time Part-time Work Status: Working without restrictions Working with restrictions Not working/off work since _____ Retired

Employer: _____ Occupation: _____

Job Description: _____ Years Employed: _____

Address: _____
Street Address/P.O. Box City State Zip

Whom may we thank for referring you? _____

Date of injury, surgery, or onset of symptoms: _____

Emergency Contact, not living with you:

What type of injury are we seeing you for?
 Auto Sports Injury No specific trauma
 Work Slip & Fall Other

Name: _____
Phone #: _____ Relationship: _____

Please provide the following information:

For Office Use Only

Copy of your Driver's License or Identification Card

PATIENT'S WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Company: _____ Claim #: _____

Adjuster's Name: _____ Adjuster's Phone #: _____ Med-Pay Balance \$ _____

ATTORNEY INFORMATION

Name of Attorney: _____ Date attorney was retained: _____

Phone #: _____ Fax #: _____

PATIENT PAIN PROFILE

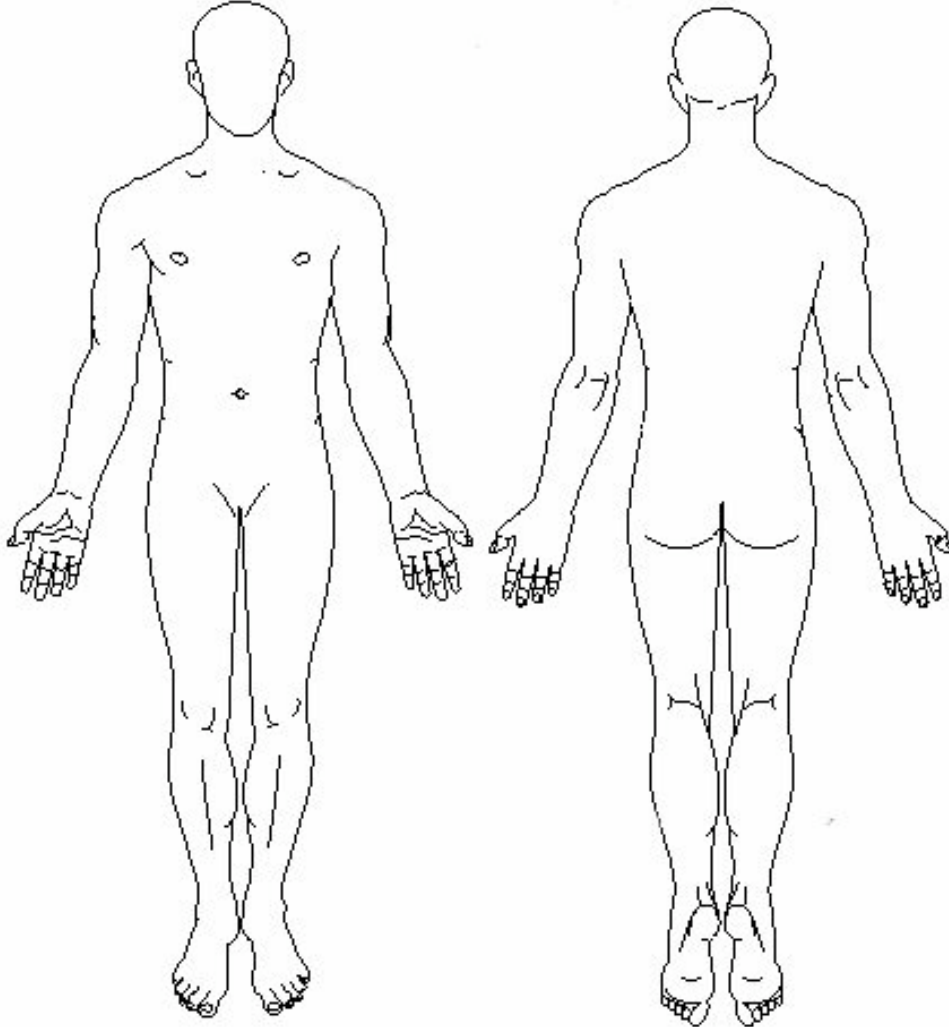
Patient Name: _____

Date: _____

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

KEY

- A = ACHE N = NUMBNESS P = PINS & NEEDLES B = BURNING S = STABBING
 O = OTHER (Please describe): _____



What percent of the time is your pain present? If your pain is there all the time, in varying degrees, that would indicate 100%.

Rate the intensity of your pain. Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you cannot perform or complete your work, social, or recreational activities.

	Symptom Description <i>Describe each symptom, including area, as clearly as possible.</i>	Frequency <i>Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours</i>	Intensity Range <i>Using a scale of 0-10, where 10 is the <u>worst</u> pain imaginable, rate the pain intensity level for each symptom.</i>
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

OSWESTRY ACTIVITY RATING SCALE

Patient Name: _____ **Date:** _____

This questionnaire has been designed to give us information as to how your pain has affected your everyday life activities. Please answer each section; marking only one statement which best describes your status today.

SECTION 1 - Pain Intensity

- ⓪ I can tolerate the pain I have without having to use painkillers.
- ① The pain is bad but I manage without taking painkillers.
- ② Painkillers give complete relief from pain.
- ③ Painkillers give moderate relief from pain.
- ④ Painkillers give very little relief from pain.
- ⑤ Painkillers have no effect on the pain and I do not use them.

SECTION 2 - Personal Care (washing, dressing, etc.)

- 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 manage most of my personal care.
- ④ I need help every day in most aspects of self-care.
- ⑤ I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights, but it gives me extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ③ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example on a table.
- ④ I can lift only very light weights.
- ⑤ I cannot lift or carry anything at all.

SECTION 4 - Walking

- ⓪ Pain does not prevent me walking any distance.
- ① Pain prevents me from walking more than 1 mile.
- ② Pain prevents me from walking more than 1/2 mile.
- ③ Pain prevents me from walking more than 1/4 mile.
- ④ I can only walk using a stick or crutches.
- ⑤ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - 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 Pain prevents me from sitting at all.

SECTION 6 - Standing

- ⓪ I can stand as long as I want to without extra pain.
- ① I can stand as long as I want, but it gives me extra pain.
- ② Pain prevents me from standing more than 1 hour.
- ③ Pain prevents me from standing more than 1/2 hour.
- ④ Pain prevents me from standing more than 10 minutes.
- ⑤ Pain prevents me from standing at all.

SECTION 7 - Sleep

- ⓪ Pain does not prevent me from sleeping well.
- ① I don't sleep well.
- ② Even when I take tablets I have less than 6 hours of sleep.
- ③ Even when I take tablets I have less than 4 hours of sleep.
- ④ Even when I take tablets I have less than 2 hours of sleep.
- ⑤ Pain prevents me from sleeping at all.

SECTION 8 - Exercise

- ⓪ I exercise and it causes no extra pain.
- ① I exercise but it causes some extra pain.
- ② I exercise but it is very painful.
- ③ My exercise is severely restricted by pain.
- ④ My exercise is nearly absent because of pain.
- ⑤ Pain prevents any exercise at all.

SECTION 9 - Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but moderately increases the degree of pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant effect on my social life apart from limiting my energetic interest.
- ④ Pain has restricted my social life to my home.
- ⑤ I have no social life because of pain.

SECTION 10 - Traveling

- ⓪ I can travel anywhere without extra pain.
- ① I can travel anywhere, but it gives me extra pain.
- ② Pain restricts me to journeys of less than 2 hours.
- ③ Pain restricts me to journeys of less than 1 hour.
- ④ Pain restricts me to journeys of less than 30 minutes.
- ⑤ Pain prevents me from traveling except to the doctor or hospital.

Score

Patient Name: _____

Date: _____

ABOUT YOUR FAMILY HISTORY

Please mark relative's current age or age at time of death.

Place an X in the boxes that apply to them. Describe "Other" and list cause of death.

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Other (Describe)
Father																		
Mother																		
Brothers/Sisters #1																		
#2																		
#3																		
#4																		
#5																		

ANY & ALL HOSPITALIZATIONS, OPERATIONS, AUTOMOBILE & ON THE JOB INJURIES

Please be as specific as possible, INCLUDING AREAS INVOLVED, EVALUATIONS, TREATMENT, AND YEAR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SERIOUS ILLNESSES

List current & past illnesses not mentioned above, including cancer, diabetes, depression, thyroid, heart disease, blood pressure, etc.

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

TESTS

Please list the MOST RECENT date.

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/ CT Scans _____

PATIENT TREATMENT HISTORY

LIST ALL DOCTORS, TESTS, AND TREATMENT YOU HAVE RECEIVED SINCE YOUR INJURY

Start with the first doctor/healthcare provider/hospital you saw after your injury and check all tests/treatments that apply

1. Name of hospital/doctor/therapist/medical center:
 Date of visit:
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

2. Name of hospital/doctor/therapist/medical center:
 Date of visit:
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

3. Name of hospital/doctor/therapist/medical center:
 Date of visit:
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

4. Name of hospital/doctor/therapist/medical center:
 Date of visit:
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

FINANCIAL POLICY

Welcome to our office! We are pleased that you have chosen Alliance Health Partners/Optima Rehabilitation to provide your care and services. We would like to take a moment to inform you of our policies, regarding payment with the office. We accept cash, personal checks and credit card (VISA, MasterCard, or Discover) for payment on your account.

INSURANCE PATIENTS WHO NEGLECT TO SUPPLY THIS OFFICE WITH THE NECESSARY INFORMATION/FORMS WITHIN A REASONABLE AMOUNT OF TIME WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

AUTO/PERSONAL INJURY INSURANCE (PIP, Med-Pay, 3rd Party, Lien) or **WORKER'S COMPENSATION**: You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

CONTRACTED INSURANCE (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, and address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service, and any amounts not covered by your insurance, including deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for payment of the entire balance due, based on our normal fee schedule. **You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you reschedule or sign a waiver for no referral or authorization thus holding you financially responsible.**

PRIVATE INSURANCE: As a courtesy, we are happy to file your insurance for you. You will be required to provide all the necessary billing information. **If you owe on your deductible or a co-insurance, we will need to collect at the time of service.** All insurance payments that are paid directly to you should be endorsed and paid to Alliance Health Partners/Optima Rehabilitation. It is your responsibility to contact your insurance in the event of non-payment.

MEDICARE: We are participating with the Medicare program. *We will submit your claim/services to Medicare. Medicare will process payment to us.* You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us.

CASH ONLY PLAN/NO INSURANCE: *Payment in full is due the day services are rendered by all patients on a cash only plan. Prompt payment is expected.* Unless prior arrangements are made, overdue accounts will incur a 1.5% interest rate per month, plus reasonable collection fees.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Alliance Health Partners/Optima Rehabilitation.

Patient's Signature (Responsible party over 18 years old)

Date

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY

Date: _____

Insurance: _____

Address: _____

Patient Name: _____

Claim #: _____

Policy #: _____

Pay to: Alliance Health Partners
3225 International Circle Suite 100
Colorado Springs, CO 80910
Phone: (719) 632-4754
Fax: (719) 471-3734
E-mail: chiro@optimarehab.com

You are instructed to pay directly to the doctor/therapist at the doctor's/therapist's office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/therapist. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment.

I hereby authorize the doctor/therapist listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Signature: **X** _____

Date: _____

Address: _____

Witness: _____

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY

Date: _____

Insurance: _____

Address: _____

Patient Name: _____

Claim #: _____

Policy #: _____

Pay to: *Optima Rehabilitation
3225 International Circle Suite 100
Colorado Springs, CO 80910
Phone: (719) 471-4221
Fax: (719) 471-3734
E-mail: pt@optimarehab.com*

You are instructed to pay directly to the doctor/therapist at the doctor's/therapist's office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/therapist. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment.

I hereby authorize the doctor/therapist listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Signature: **X** _____

Date: _____

Address: _____

Witness: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient Name (print): _____

Relationship to patient: _____

Signature: _____