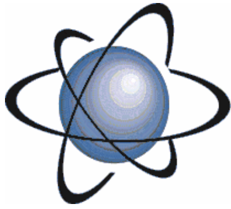


C.O.R.E. PHYSICAL THERAPY

CENTER OF REHAB EXCELLENCE

Dear Patient:

We would like to take a moment to personally welcome you to our practice. We are pleased that you have chosen CORE Physical Therapy to be your rehabilitation provider. Before we get started, we would like to inform you that Electronic Medical Records (EMR) is now becoming the standard in the medical community. As a result, all communication is managed electronically through E-mail and mobile devices. Therefore, before we can move forward we require that you supply us with your E-mail address and mobile phone number. We assure you that we do not endorse any form of spam and will not in any way sell your information.

E-mail Address: ______________________________

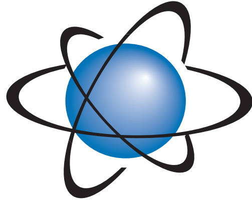
Mobile Phone Number: ______________________________

Appointment reminders will automatically be sent by E-mail. If you would like additional forms of appointment reminders, please indicate below.

☐ Text Message reminders

☐ Phone Call reminders

10162 Adams Avenue · Huntington Beach, CA 92646
Tel: 714.861.4440 · Fax: 714.861.4450 · E-mail: corepthb@gmail.com · Web: corepthb.com



CENTER OF REHAB EXCELLENCE
PHYSICAL THERAPY

PATIENT INFORMATION

DATE ________________

NAME ____
title first middle last suffix

ADDRESS ______________________________ HOME PHONE (   ) ____________

CITY ______________ STATE ____ ZIP ______ CELL PHONE (   ) ____________

EMail ______________________________ WORK PHONE (   ) ____________

EMERGENCY CONTACT ______________________________ PHONE (   ) ____________

HOW DID YOU HEAR ABOUT US? ______________________________

SSN ______________________ SEX m f DATE OF BIRTH __/__/__

MARITAL STATUS single married divorced separated widowed STUDENT STATUS F/T P/T

OCCUPATION ______________________________ WORK PHONE (   ) ____________

EMPLOYER ______________________________ STATUS (circle one)

f/t p/t unemployed
self- employed retired
active military duty

ADDRESS ______________________________

CITY ______________ STATE ____ ZIP ______

GUARANTOR (if patient is a minor) ______________________ DATE OF BIRTH __/__/__

ADDRESS ______________________________ HOME PHONE (   ) ____________

CITY ______________ STATE ____ ZIP ______ CELL PHONE (   ) ____________

REFERRING PHYSICIAN ______________________________

ADDRESS ______________________________ PHONE (   ) ____________

CITY ______________ STATE ____ ZIP ______ FAX (   ) ____________

DIAGNOSIS ______________________________

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED. HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

CENTER OF REHAB EXCELLENCE LEGAL DUTY

Center of Rehab Excellence, APTC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Center of Rehab Excellence uses your personal health information primarily for treatment; obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Center of Rehab Excellence may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public heath/statistical purposes. We also provide information when required by law. In any other situations, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Center of Rehab Excellence may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the office and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Center of Rehab Excellence will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Center of Rehab Excellence
Attn: Lupe Koahou, Privacy Officer
10162 Adams Avenue Huntington Beach, CA 92646
Telephone: (714) 861-4440 (714) 861-4450 fax

Center of Rehab Excellence

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Center of Rehab Excellence's Notice of Information Practices. I understand that Center of Rehab Excellence 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 Center of Rehab Excellence 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 Center of Rehab Excellence'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

If patient is under 18 years of age:

____
Parent Name

____
Signature

____
Date

Center Of Rehab Excellence, A Physical Therapy Corporation

FINANCIAL POLICY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Center Of Rehab Excellence, APTC (CORE PT)** to furnish medical care and treatment to: ____, as considered necessary and proper in evaluating or treating his/her physical and mental condition. I hereby instruct and direct my Insurance Company to issue check(s) made out and mailed directly to: **CORE PT**, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy.

____
Initial

FINANCIAL POLICY STATEMENT

As a courtesy to you, we may bill your insurance carrier. However, you are responsible for the entire bill for services rendered. If we bill your insurance carrier and we do not receive full payment within 90 days, the balance will be due in full from you. In the event your insurance carrier performs a post treatment review and deems the services not medically necessary, you will be financially responsible for those denied charges. In the event that your insurance company requests a refund of payment made, upon **CORE PT** presenting you with notice of the refund made, you will be immediately responsible for the entire amount of money refunded to your insurance company. In the event your employer establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining. In the event that payment is made directly to you for services billed by us, you are obligated to promptly remit the same compensation. 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 to you.

"I understand and agree that if I fail to make any of the payments for which I am responsible, in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees."

____
Initial

CO-PAYMENTS

Any Co-pays and Deductibles are due at the beginning of each visit. If your co-pay is a percentage, rather than a fixed dollar amount, there is no way to know exactly what the co-pay will be. In that case, and in the case of a deductible, we will collect an estimated amount on each visit. Any difference will be handled by our billing department after the claim is processed by your insurance company.

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from responsibility for their account balance. **CORE PT** *encourages you to contact your Insurance carrier for Physical Therapy benefits under the provisions of your plan.*

Outstanding balances that remain unpaid will ultimately be referred to a collection agency, attorney, or collections will be pursued through other legal means. Additional costs incurred in this process will be added to your financial responsibilities.

____
Initial

MISSED APPOINTMENTS

We require advanced notification for any appointment that needs to be cancelled. Notice of at least a full 24 hours is required in order to allow us time to fill the missed appointment slot. If you fail to give us adequate notice, or if you "no-show" for your appointment, you will be charged a $30 fee.

____
Initial

TERMS AND LATE FEES

CORE PT provides net thirty (30) days payment terms to the patient. This means that the invoice is due within thirty (30) days of being sent. If CORE PT does not receive payment within thirty (30) days of the invoice being sent, patient will incur a late fee of 5% per month (60% APR) on the balance that is past due, including previously accrued late fees.

____
Initial

RETURNED CHECKS

Checks returned due to insufficient funds will be assessed an additional $45 processing fee for the first occurrence. The second time a check is returned due to insufficient funds, there will be a $75 processing fee. Any payment received after that point must be paid by cash, money order, or credit card. You hereby authorize **CORE PT** to charge your credit card for returned checks as soon as it receives notice of such occurrence.

____
Initial

ARBITRATION PROVISION

Any dispute, claim or controversy arises out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Orange County, California, before one arbitrator. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures. Judgment on the Award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. Allocation of Fees and Costs: The arbitrator may, in the Award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE RELATING TO THIS AGREEMENT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

____
Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby certify that I have received a copy of the Notice of Privacy Practices. The Notices of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bill, or in the performance of **CORE PT** health care operations. The Notice of Privacy Practices also describes my rights and **CORE PT's** duties with respect to my protected health information. **CORE PT** reserves the right to change privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent me via mail, fax, or e-mail, or by asking for a copy at my next visit at the clinic. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that **CORE PT** is not required to agree to the restrictions requested.

____
Initial

I have read, understand, and agree to all of the above. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

____
Patient/Guardian/Responsible Party　　　　　　　　Date

____
CORE PT Representative/Witness

MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ REFERRING MD: ____________________

What is your reason for seeking treatment? (If more than one reason, please list in order of importance)

____

____

Date of injury/surgery/beginning of symptoms? ______________________________

Are you currently taking any prescription or non-prescription medication? YES NO

Anti-inflammatories _________ Muscle Relaxers _________ Pain Medication _________

List Medications: ____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Physical Therapy	______	______	X-Ray	______	______
Chiropractic	______	______	MRI	______	______
Occupational Therapy	______	______	EMG/NCV	______	______
Emergency Room	______	______	Myelogram	______	______
Orthopedist	______	______	CT Scan	______	______
Neurologist	______	______	Massage Therapy	______	______
General MD	______	______	Speech Therapy	______	______

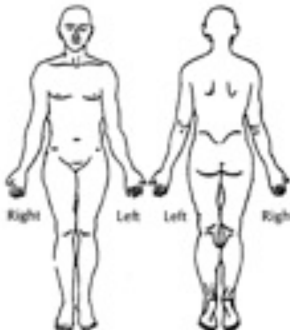
Explain: ____

Do you have any problems with:

	YES	NO		YES	NO		YES	NO
Allergies	_____	_____	Breathing Problems	_____	_____	Pregnant	_____	_____
Heart Conditions	_____	_____	Arthitis	_____	_____	Cancer	_____	_____
High Blood Pressure	_____	_____	Diabetes	_____	_____	Metal Implants	_____	_____
Seizure Disorder	_____	_____	Hernia	_____	_____	Recent weight changes	_____	_____
Balance Problems	_____	_____	Dizzy Spells	_____	_____	Stroke	_____	_____
Vision Problems	_____	_____	Headaches	_____	_____	Sleeping Problems	_____	_____
Hearing Problems	_____	_____	Pacemaker	_____	_____	Infectious Diseases	_____	_____

Do you smoke? YES / NO Do you drink alcohol? YES / NO Do you use recreational drugs? YES / NO

Circle the area of discomfort on the body charts below:



RATE THE INTENSITY OF YOUR PAIN											
AT BEST	0	1	2	3	4	5	6	7	8	9	10
AT WORST	0	1	2	3	4	5	6	7	8	9	10
CONSTANTLY	0	1	2	3	4	5	6	7	8	9	10

____

PATIENT NAME (PRINT) PATIENT/GUARDIAN SIGNATURE DATE

FUNCTIONAL QUESTIONNAIRE

Patient Name ______________________________ Date ____________

This questionnaire will give your treating therapist information about how your 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
Ⓐ I have no pain at the moment.
Ⓑ The pain is very mild at the moment.
Ⓒ The pain comes and goes and is moderate.
Ⓓ The pain is fairly severe at the moment.
Ⓔ The pain is very severe at the moment.
Ⓕ The pain is the worst imaginable at the moment.

Sitting
Ⓐ I can sit in any chair as long as I like.
Ⓑ I can only sit in my favorite chair as long as I like.
Ⓒ Pain prevents me from sitting more than 1 hour.
Ⓓ Pain prevents me from sitting more than ½ hour.
Ⓔ Pain prevents me from sitting more than 10 minutes.
Ⓕ I avoid sitting because it increases pain immediately.

Walking
Ⓐ I have no pain while walking.
Ⓑ I have some pain while walking but it doesn't increase with distance.
Ⓒ I cannot walk more than 1 mile without increasing pain.
Ⓓ I cannot walk more than ½ mile without increasing pain.
Ⓔ I cannot walk more than ¼ mile without increasing pain.
Ⓕ I cannot walk at all without increasing pain.

Driving
Ⓐ I can drive my car without any pain.
Ⓑ I can drive my car as long as I want with slight pain.
Ⓒ I can drive my car as long as I want with moderate pain.
Ⓓ I cannot drive my car as long as I want because of moderate pain.
Ⓔ I can hardly drive at all because of severe pain.
Ⓕ I cannot drive my car at all because of pain.

Social Life
Ⓐ My social life is normal and gives me no extra pain.
Ⓑ My social life is normal but increases the degree of pain.
Ⓒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
Ⓓ Pain has restricted my social life and I do not go out very often.
Ⓔ Pain has restricted my social life to my home.
Ⓕ I have hardly any social life because of the pain.

Work
Ⓐ I can do as much work as I want.
Ⓑ I can only do my usual work but no more.
Ⓒ I can only do most of my usual work but no more.
Ⓓ I cannot do my usual work.
Ⓔ I can hardly do any work at all.
Ⓕ I cannot do any work at all.

Sleeping
Ⓐ I have no trouble sleeping.
Ⓑ My sleep is slightly disturbed (less than 1 hour sleepless).
Ⓒ My sleep is mildly disturbed (1-2 hours sleepless).
Ⓓ My sleep is moderately disturbed (2-3 hours sleepless).
Ⓔ My sleep is greatly disturbed (3-5 hours sleepless).
Ⓕ My sleep is completely disturbed (5-7 hours sleepless).

Personal Care
Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
Ⓑ I do not normally change my way of washing or dressing even though it causes some pain.
Ⓒ Washing and dressing increases the pain but I manage not to change my way of doing it.
Ⓓ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
Ⓔ Because of the pain I am unable to do some washing and dressing without help.
Ⓕ Because of the pain I an unable to do any washing and dressing without help.

Standing
Ⓐ I can stand as long as I want without pain.
Ⓑ I have some pain while standing but it does not increase with time.
Ⓒ I cannot stand for longer than 1 hour without increasing pain.
Ⓓ I cannot stand for longer than ½ hour without increasing pain.
Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
Ⓕ I avoid standing because it increases pain immediately.

Lifting
Ⓐ I can lift heavy weights without extra pain.
Ⓑ I can lift heavy weights but it causes extra pain.
Ⓒ Pain prevents me from lifting heavy weights off the floor.
Ⓓ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table).
Ⓔ Pain prevents me from lifting heavy weights off the floor but I can manage light to medium weights if they are conveniently positioned.
Ⓕ I can only lift very light weights.

Activities (Recreation / Travel / Exercise)
Ⓐ I am able to engage in all my activities without pain.
Ⓑ I am able to engage in all my usual activities with some pain.
Ⓒ I am able to engage in most but not all my usual activities because of pain.
Ⓓ I am only able to engage in a few of my usual activities because of pain.
Ⓔ I can hardly do any activities because of pain.
Ⓕ I cannot do any activities at all.

Changing Degree of Pain
Ⓐ My pain is rapidly getting better.
Ⓑ My pain fluctuates but overall is definitely getting better.
Ⓒ My pain seems to be getting better but improvement is slow.
Ⓓ My pain is neither getting better or worse.
Ⓔ My pain is gradually worsening.
Ⓕ My pain is rapidly worsening.