# LOR Physical Therapy Intake Form

Last Name _____

First Name _____ DOB _____

Home Address _____

Billing Address (leave blank if same) _____

Phone number _____(we will text for waitlist openings)

2nd Phone number (optional) _____

Email address _____ (we will email appt reminders)

## Emergency Contact Information / Guardian Information (If patient is minor)

Last Name _____ First Name _____ DOB _____

Home Address _____

Phone Number _____ Relationship to Patient _____

☐ It is ok to share my Protected Health Information (PHI) with my emergency contact

## Payment Information

Will you be using insurance for your PT sessions? ☐ Yes ☐ No ☐ WorkComp

Primary Insurance Carrier _____

ID # _____ Group # _____

Secondary Insurance Carrier _____

ID # _____ Group # _____

## Referral Source – How did you hear about us?

☐ Facebook ☐ Internet reviews (Google, Yelp)

☐ Workshop ☐ Walk-In ☐ Past Patient

☐ Doctor Referral – Name: _____

☐ Personal Referral – Name: _____

☐ Other: _____

Were you referred to a specific therapist? Name: _____

# Medical History Form

*Please indicate the past/current presence of the following conditions by marking off the appropriate checkbox. Leaving a checkbox blank means you do **not** and have **never** shown symptoms of the following conditions.*

- ☐ Allergies
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vision Problems

*In the past 3 months have you had or experienced any of the following? (mark checkbox if "yes")*

- ☐ Changes in your health
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Unexplained Weight Loss
- ☐ Numbness or Tingling
- ☐ Changes in Appetite
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Upper Respiratory Infection
- ☐ Pneumonia
- ☐ Urinary Tract Infection
- ☐ Changes in Bowel or Bladder Function
- ☐ Lumps/Thickening of Skin

Do you have a transplanted organ? ☐ Y ☐ N  Do you have any joint replacements? ☐ Y ☐ N

Indicate how you sleep at night: ☐ No difficulty ☐ Moderate difficulty ☐ Need medication to sleep

Do you or did you used to smoke? ☐ Y ☐ N  Are you pregnant (females only)? ☐ Y ☐ N

Do you drink alcoholic beverages? ☐ Y ☐ N  Date of last physical exam: _____

Height _____  Weight _____  What is your **current** pain level (1-10 (worst))? _____

Please list the type/date of any operations you have had: _____

_____

_____

Please list all current medications: _____

_____

_____

NAME: _____ DATE: _____

# Lower Extremity Functional Scale

*Please rate your difficulty level with activity by marking off the appropriate checkbox using the following scale.*

| *Difficulty Level ----------> * | *Extreme difficulty or unable to perform activity (0)* | *Quite a bit of difficulty (1)* | *Moderate difficulty (2)* | *A little bit of difficulty (3)* | *No difficulty (4)* |
|---|---|---|---|---|---|
| 1. Any of your usual work, housework or school activities. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. Your usual hobbies, recreational or sporting activities. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. Getting into or out of the bath. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 4. Walking between rooms. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 5. Putting on your shoes or socks. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 6. Squatting. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 7. Lifting an object, like a bag of groceries, from the floor. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 8. Performing light activities around your home. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 9. Performing heavy activities around your home. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 10. Getting into or out of a car. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 11. Walking two blocks. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 12. Walking a mile. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 13. Going up or down ten stairs (one flight of stairs). | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 14. Standing for one hour. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 15. Sitting for one hour. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 16. Running on even ground. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 17. Running on uneven ground. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 18. Making sharp turns while running fast. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 19. Hopping. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 20. Rolling over in bed. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

NAME: _____ DATE: _____

# Modified Oswestry Disability Scale (10 Questions)

*Please rate your pain level with activity by marking off the appropriate checkbox.*

### 1. Pain Intensity

- ☐ 0- I can tolerate the pain I have without having to use pain medication.
- ☐ 1- The pain is bad, but I can manage without having to take pain medication.
- ☐ 2- Pain medication provides me with complete relief from pain.
- ☐ 3- Pain medication provides me with moderate relief from pain.
- ☐ 4- Pain medication provides me with little relief from pain.
- ☐ 5- Pain medication has no effect on my pain.

### 2. Personal Care (washing, dressing, etc)

- ☐ 0- I can take care of myself normally without causing increased pain.
- ☐ 1- I can take care of myself normally but it increases my pain.
- ☐ 2- It is painful to take care of myself, and I am slow and careful.
- ☐ 3- I need help but I am able to manage most of my personal care.
- ☐ 4- I need help every day in most aspects of my care.
- ☐ 5- I do not get dressed, wash with difficulty, and stay in bed.

### 3. Lifting

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

### 4. Walking

- ☐ 0- Pain does not prevent me from walking any distance.
- ☐ 1- Pain prevents me from walking more than one mile.
- ☐ 2- Pain prevents me from walking more than half a mile.
- ☐ 3- Pain prevents me from walking more than one quarter of a mile.
- ☐ 4- I can only walk with crutches or a cane.
- ☐ 5- Pain prevents me from walking at all / I am in bed most of the time.

### 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 one hour.
- ☐ 3- Pain prevents me from sitting more than a half hour.
- ☐ 4- Pain prevents me from sitting more than ten minutes.
- ☐ 5- Pain prevents me from sitting at all.

### 6. Standing

- ☐ 0- I can stand as long as I want without increased pain.
- ☐ 1- I can stand as long as I want, but it increases my pain.
- ☐ 2- Pain prevents me from standing more than one hour.
- ☐ 3- Pain prevents me from standing more than a half hour.
- ☐ 4- Pain prevents me from standing more than ten minutes.
- ☐ 5- Pain prevents me from standing at all.

**7. Sleeping**

- ☐ 0- Pain does not prevent me from sleeping well.
- ☐ 1- I can sleep well only by using pain medication.
- ☐ 2- Even when I take pain medication, I sleep less than six hours.
- ☐ 3- Even when I take pain medication, I sleep less than four hours.
- ☐ 4- Even when I take pain medication, I sleep less than two hours.
- ☐ 5- Pain prevents me from sleeping at all.

**8. Employment/Homemaking**

- ☐ 0- My normal homemaking/job activities do not cause pain.
- ☐ 1- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ 2- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg. lifting, vacuuming).
- ☐ 3- Pain prevents me from doing anything but light duties.
- ☐ 4- Pain prevents me from doing even light duties.
- ☐ 5- Pain prevents me from performing any job or homemaking chores.

**9. Traveling**

- ☐ 0- I can travel anywhere without increased pain.
- ☐ 1- I can travel anywhere, but it increases my pain.
- ☐ 2- My pain restricts my travel over two hours.
- ☐ 3- My pain restricts my travel over one hour.
- ☐ 4- My pain restricts my travel to under a half hour.
- ☐ 5- My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Social Life**

- ☐ 0- My social life is normal and does not increase my pain.
- ☐ 1- My social life is normal, but it increases my level of pain.
- ☐ 2- Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- ☐ 3- Pain prevents me from going out very often.
- ☐ 4- Pain has restricted my social life to my home.
- ☐ 5- I have hardly any social life because of my pain.

NAME: _____ DATE: _____

# LOR Physical Therapy Payment Policy

Welcome to the LOR Family! We look forward to helping you heal and getting you back to doing the things you love most. As part of your continuing treatment, we require that payment for physical therapy sessions be remitted at time of service (ie. when you visit the lovely front office staff at the check-in desk). You have the option to keep a credit card on file if that is easier for you, or simply pay at check-in each visit. You may also set up a payment plan where you pay weekly for the week **ahead**. **ALL MINORS MUST PROVIDE GURANTOR PAYMENT OR HAVE A CREDIT CARD ON FILE FROM THE GUARANTOR AT TIME OF SERVICE. IF PAYMENT IS NOT REMITTED PRIOR TO TIME OF SERVICE, THE PATIENT WILL NOT BE SEEN FOR TREATMENT.**

Any overpayments made due to unforeseen patient cancellations with 24-hour notice, difference in claims remittance advice (what the insurance company states you owe for patient responsibility), etc. will be credited back to your account with us once final claims process. The patient has the right to request a refund check once all claims have correctly processed and services with us are terminated.

If you are the Guarantor of a minor, or are a patient that would like to fill out the Credit Card on File form, please do so below. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

Cardholder name: _____

Card number: _____

Expiration Date: _____ CVV (3 digits on back): _____

Billing address zip code: _____

**By leaving my credit card on file, I, _____**

**authorize Grace Physical Therapy dba Laguna Orthopedic Rehabilitation to charge my credit card above for the agreed upon services. I understand that my information will be saved on my file for future transactions on my account.**

**SIGNATURE OF PATIENT/GUARANTOR:_____**

**PATIENT NAME: _____ DATE: _____**

**GUARANTOR NAME: _____ DATE: _____**

## Acknowledgment of Financial Responsibility

At LOR Physical Therapy, we pride ourselves on patient communication in all aspects of our office, from your therapy session to patient financial responsibility. By becoming our patient and part of the LORPT family, you certify that all the information provided to us is true and correct. You authorize the clinic and its business associates (like AIM Medical Services – the billing company) to release information to your insurance company, if required, to expedite payment or obtain approval for physical therapy visits. You also authorize payment directly to Grace Physical Therapy, Inc. (dba – Laguna Orthopedic Rehabilitation aka LOR Physical Therapy). If needed, you authorize Grace Physical Therapy, Inc. to release your information to the Centers for Medicare and/or Medicaid services to determine the benefits payable for your related services. You acknowledge that no guarantees, either expressed or implied, have been made regarding the outcome of any treatments or procedures; it is ultimately up to your insurance company to determine the medical necessity of your visits and condition.

You also understand that insurance verification is **not** a guarantee of coverage and that it is ultimately the patient's responsibility to obtain complete insurance coverage from member services (usually located with a phone number on the back of the insurance card). All benefit information given to the patient is considered an estimate provided to the office by your insurance carrier. If claims process at amounts different than what was provided by your insurance upon our verification of your coverage, you acknowledge that it is the financial responsibility of you, the patient or guarantor, to remit payment for all services rendered based on what your insurance carrier deems as patient responsibility.

It is your responsibility as the patient to provide complete and **accurate** insurance information at your time of service, including providing a valid insurance card (either physical or digital) that may be copied so that we may bill your insurance for you. If, at time of service, your coverage changes or you do not provide the office with accurate updated insurance information, you, the patient or guarantor, are ultimately responsible for any services not paid for by the insurance company, eg. like if it is related to timely filing or obtaining authorizations for visits. Claims that come back denied because an inaccurate representation of the patient's insurance was given will result ultimately in complete financial responsibility of the patient/guarantor. Communication is key!

**By signing below you acknowledge LOR Physical Therapy's policy regarding insurance verification and agree to inform our office immediately of any policy changes with your insurance company so that we may continue to bill the proper insurance entity for you.** 😊

**SIGNATURE OF PATIENT/GUARANTOR:**_____

**PATIENT NAME:** _____ **DATE:** _____

**GUARANTOR NAME:** _____ **DATE:** _____

## Cancellation & No Show Policy

Thank you for choosing LOR Physical Therapy as your rehabilitation provider. At LORPT we strive to make sure every patient in need is taken care of across all ages and aspects of treatment. To make sure patients are able to be seen for treatment, we require a **24 hour notice** in the event of a patient cancellation. This is to help ensure that patients on the waitlist have the opportunity to get on the schedule when they are needing therapy most. Every patient is allowed one "freebie" for less than 24 hour notice (last minute schedule change, got sick, etc.). After which the following cancellation policy will take effect:

*1st offense - $35 cancellation fee*

*2nd offense - $50 cancellation fee*

*3rd offense - $75 cancellation fee*

All charges related to cancellations are **NOT** covered by insurance and are the financial responsibility of the patient/guarantor. After a third cancellation in violation of the 24 hour policy, the patient will be allowed to schedule **SAME DAY ONLY** – that is, that patient can call the clinic the day of patient availability and LORPT will offer spots that are available for that day only. Repeat offenders of 3 times or more will not be allowed to schedule for future dates of service. Please understand that we have this policy in place so that patients on the waitlist are able to get in for their much needed treatment. The Owner and Office Manager are to be consulted in cases of extenuating circumstances and are the only parties able to waive any outstanding cancellation charges. We reserve the right to cease treatment of any patient if the 24 hour policy is not respected and you remain inconsistent with appointment attendance.

If you are a Workman's Compensation patient the above charges will not apply, however documentation of your missed appointments will be forwarded to your Case Manager/Adjuster and Worker's Comp insurance, which could jeopardize your ability to obtain future authorization for visits. **WE WILL REPORT YOU TO YOUR WORKCOMP INSURANCE AND RECOMMEND THAT TREATMENT BE CONTINUED AT ANOTHER LOCATION IF YOU CANCEL / NO SHOW MORE THAN TWO TIMES ON THE SCHEDULE**. Again, we want to make sure every patient looking to get in for treatment can be seen without unnecessary holds on the schedule.

**BY SIGNING BELOW YOU ACKNOWLEDGE THE 24 HOUR CANCELLATION POLICY AND AGREE TO THE TERMS ABOVE.**

**SIGNATURE OF PATIENT/GUARANTOR:**_____

**PATIENT NAME:** _____ **DATE:** _____

**GUARANTOR NAME:** _____ **DATE:** _____

# Notice of Privacy Practices

*This notice describes how medical information related to your condition may be used and disclosed, and how you are able to get access to this information. Please review.*

This notice serves to provide you, the patient, how Grace Physical Therapy dba Laguna Orthopedic Rehabilitation may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, healthcare operations, or other purposes as permitted by law. It also describes your rights to access and control your PHI (PHI including demographic information and other information that may identify and relate to your past, present, or future physical or mental health condition and related health care services). Please note that Grace Physical Therapy may change its policy at any time, with the current policy being available in paper form at front office. You may obtain the aforementioned revised copy of our Notice of Privacy Practices at any time. The current Notice of Privacy Practices remains in effect until replaced.

**USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

The following is a list of possible ways we may use and disclose your PHI:

*For Treatment:* We will use your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party, such as a referring doctor, physician assistant, nurse, and others responsible for your care.

*For Payment:* We will use your PHI as necessary to obtain payment for your healthcare services, including use of insurance verifications and authorizations so that you may be approved for treatment with your insurance carrier.

*For Healthcare Operations:* We may use or disclose your PHI as necessary for routine quality assessments, performance evaluations, training, accreditation, certificates, licenses, and credentials we need to serve you.

**WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION AS REQUIRED BY LAW:** Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation.

**OTHER DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT LISTED WILL REQUIRE WRITTEN AUTHORIZATION FROM YOU DIRECTLY, UNLESS SUCH DISCLOSURE IS REQUIRED BY LAW.**

As a patient of Grace Physical Therapy dba Laguna Orthopedic Rehabilitation, you maintain the following rights:

- The right to obtain and copy your protected health information, with associated fees per California law.
- The right to receive an accounting of your PHI disclosures for purposes other than treatment, payment, and healthcare operations or as required by law.
- The right to request additional restrictions on the use or disclosure of your protected health information, except those required by law. Providers (such as Grace Physical Therapy) are not required to adhere to these additional restrictions, but we will take all requests into consideration.
- The right to amend your medical information per your request. If your request for amendment is denied, you may write a letter of disagreement that will be added to the information that you wanted changed.
- The right to request that we communicate with you about your protected health information by different means or to a different location, with all such requests being made in writing.
- The right to file a complaint to us or the US Department of Health and Human Services if you believe your privacy rights have been violated by our organization.
- The right to receive this notice as a paper copy for your records at any time.

**IF YOU HAVE ANY QUESTIONS ABOUT THE NOTICE OF PRIVACY PRACTICES PLEASE CONSULT OUR FRONT OFFICE.**

## Acknowledgment of Receipt of Notice of Privacy Practices

As part of your healthcare, Grace Physical Therapy dba Laguna Orthopedic Rehabilitation creates and maintains health records describing your health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning your care and treatment.
- A means of communication among other health professionals who contribute to your care.
- A source for applying your diagnosis and clinical information to your financial responsibility.
- A means by which a third party-payer (e.g. Insurance carrier or Workman's Compensation) can verify that the services billed were provided.
- A tool for routine healthcare operations such as assessing quality and outcomes.

**By signing below, you acknowledge that you have received and read our Notice of Privacy Practices, a copy of which can be requested at any time for your records.**

**SIGNATURE OF PATIENT/GUARDIAN: _____**

**PATIENT NAME: _____ DATE: _____**

**GUARDIAN NAME: _____ DATE: _____**

## Informed Consent of Physical Therapy Services

By becoming our patient, you also realize that response to treatment will vary from person to person, meaning as your provider it will not always be possible to accurately predict a patient's reaction to a specific procedure or modality. We cannot guarantee your reaction to a specific treatment nor can we guarantee that your treatment will resolve the condition for which you are seeking treatment (although we are always very hopeful it will! 😊 ). You acknowledge there is a remote possibility that your treatment may aggravate symptoms or result in pain or injury.

As our patient, you have the right to ask the type of treatment your therapist is planning for you based on your personal history, symptoms, diagnosis, and test results. You may also discuss with your physical therapist the risks and benefits associated with any type of treatment to be rendered for your care. And most importantly, you have the right to decline any type of treatment to be performed during your care, before or during your therapy session.

**By signing below, you acknowledge the risks and benefits associated with physical therapy treatment and understand your rights as the patient to discuss or decline any type of treatment that may be planned for your care.**

**SIGNATURE OF PATIENT/GUARDIAN: _____**

**PATIENT NAME: _____ DATE: _____**

**GUARDIAN NAME: _____ DATE: _____**

YOU FINISHED! PLEASE EMAIL THIS PACKET TO INTAKE@LORPT.COM THANK YOU!