Spinal Care Associates

OUTPATIENT QUESTIONNAIRE

Please answer the following questions as completely as possible as they apply to you.

Name: _____ Age: _____ D.O.B.: _____

Type of Insurance: _____ Dominant Hand: R☐ L☐

Date of injury/ onset of symptoms: _____ Surgery date related to current injury: _____

Type of surgery related to current injury: _____ How did you hear about us? _____

Name of doctor referring you to us: _____ Date of return to doctor: _____

Have you fallen in the past 6 months? Y☐ N☐ Was this injury due to an accident? Y☐ N☐

Is this injury work related? Y☐ N☐

Describe the nature and cause of your current problem: _____

_____

Have you been injured to the same area previously? Y☐ N☐ If yes, when and how? _____

Employer: _____ Job Title: _____

Your goal for therapy: _____

Do you have any pain? Y☐ N☐ If yes, where and describe it? _____

What increases your pain? _____What decreases your pain? _____

Mark on the diagrams to the right where your pain is, if any:

Rate your pain on the scale below.

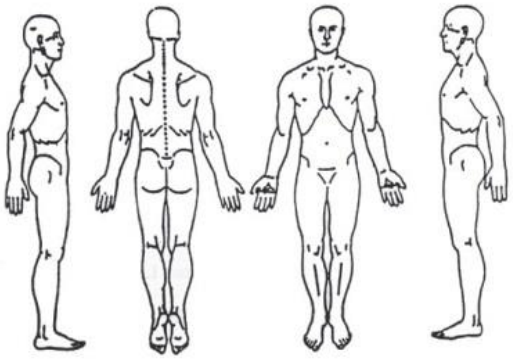
Mark "0" for "no pain"

Mark "10" for "as bad as it can be"

Worst 0 1 2 3 4 5 6 7 8 9 10

Current 0 1 2 3 4 5 6 7 8 9 10

Best 0 1 2 3 4 5 6 7 8 9 10



Describe your daily activities at home or work: _____

If you have been to physical therapy before, indicate when and for what reason: _____

_____

List all medications you are taking: _____

List any recent tests you have had and dates (ie X-rays, MRI): _____

List any surgeries you have had and the dates: _____

_____

Please check any of the following which may apply to you:

____Pacemaker ____Circulatory Problems ____High Blood Pressure ____Pregnancy

____Diabetes ____ Sensory Problems ____Metal Implants ____Heart Problems

____Seizures ____History of Cancer ____History of Smoking ____Osteoarthritis

____History of Falls

Spinal Care Associates – Patient Registration Form

Patient Information

Patient Name_____ Date of Birth _____/_____/_____

Marital Status: Single/Married/Widowed SS#_____

Home Number_____ Cell_____ Work_____

For e-mail appointment reminders, please provide your e-mail address_____

Address_____ City_____ State_____ Zip Code_____

Place of Employment:_____

Emergency Contact Person:_____ Contact Number_____

Parent or Guardian's Name (If patient is a minor)_____

Insurance Information

Primary Insurance Name:_____

ID#_____ Group_____

Insured:_____ Date of Birth:_____/_____/_____ SS#:_____

Secondary/Supplemental Insurance Name_____

ID#_____ Group_____

Insured:_____ Date of Birth:_____/_____/_____ SS#:_____

Authorizations and Assignments

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services or supplies rendered. I hereby authorize payment to go directly to Spinal Care Associates. I accept full financial responsibility for any amount not paid by my insurance carrier. In the event my unpaid account becomes delinquent, I understand that collection fees equal to 40% of the unpaid balance may be invoiced to my account. I hereby authorize Spinal Care Associates to release any medical information necessary to process my claim(s) as requested by my insurance company. I hereby consent to receive treatment as prescribed by my physician and/ or as recommended by the treating therapist in the accordance with my established plan of care. I also understand that I have the right to refuse treatment at any time.

_____

Patient's Signature (Or Guardian) Date

Workman's Comp Patients Only

I hereby give consent to Spinal Care Associates to notify my case manager and/ or physician in the event that I miss or cancel two scheduled appointments. I also understand that my case manager and physician may have access to my clinical & attendance records at any time.

_____

Patient's Signature (Or Guardian) Date

Spinal Care Associates

(405)348-5901

305 North Broadway

Edmond, OK 73034

Dear Patient:

In compliance with the Health Insurance Portability & Accountability Act (HIPAA), Spinal Care Associates is required to advise you of your office procedures regarding your Personal Health Information (PHI). In an effort to provide you with this information, we are supplying you with a copy of our "Notice of Privacy Practices" for your review.

Please take comfort in knowing that our office is making every effort to ensure that your health information is handled in the most confidential and private manner possible.

I acknowledge that I have received a copy of the "NOTICE OF PRIVACY PRACTICES" provided to me by Spinal Care Associates.

Signature of Patient

Date

Spinal Care Associates

(405)348-5901

305 North Broadway

Edmond, OK 73034

Notice of Miscellaneous Charges

Some charges received during your physical therapy may not be reimbursed through your personal insurance company (Blue Cross Blue Shield, Medicare, etc.) Those charges will be considered your responsibility. Those charges include but are not limited to electrical stimulation, moist heat/ cold packs, ultrasound, electrodes, putty, pulleys, etc. These charges will be subjected to the same collection policy as co-pays, co-insurance and deductibles.

_____ _____

Signature Date

_____ _____

Witness Signature Date

EXERCISE/ TREATMENT FLOW SHEET

Patient Name:_____ Referring Physician:_____

Diagnosis:_____

Insurance Type: _____RDA_____

Date						
Rx Time In/ Out						
# of Visits						
Treatment						

Spinal Care Associates 305 North Broadway Edmond, OK 73034
Phone: (405) 348-5901 Fax: (405) 348-5923

Thank you!

for choosing

Spinal Care Associates: Sheri Davenport, RPT

As your physical therapy clinic, please be assured that our staff of qualified professionals will make every effort possible to provide you with the highest quality of care in a friendly and caring environment. Our goal is to effectively treat your problem, as well as educate you on the nature of your injury and YOUR role in speeding the healing process.

Consistent attendance is essential to facilitate optimal results from your physical therapy. Communication, cooperation and teamwork between the patient, therapist, and physician are also important keys to ensuring a successful outcome.

We strongly encourage you to ask questions, express concerns, and advise our staff promptly of any changes that may occur during your course of treatment.

Clinic Hours:

Monday – Thursday

8AM – 5PM

What to wear:

The therapist will need to have access to the body part that is being treated; therefore, it is essential that you dress accordingly. Loose clothing, such as T-shirts, shorts and sweat pants are recommended. You may bring clothes to change into if needed. Lockers are available for personal items.

Appointments:

Appointments are scheduled in advance. Promptness and compliance with attendance is expected and appreciated. In the event that you are unable to keep your scheduled appointment time, contact our office as soon as possible to reschedule. Please be aware that late arrivals may be asked to reschedule.

*IMPORTANT: Our offices reserve the right to charge all patients a fee of $25 for cancelled or missed appointments without prior notification and legitimate reasons (I.E. illness, emergency, and doctors' appointment).

Children:

As a courtesy to other patients, in addition to safety concerns for all, children are not allowed in the treatment areas during clinic hours. This will be strictly enforced.

Cell Phones:

The use of cell phones during treatment sessions has proven to be very distracting for the patient and therapist, as well as other patients in the clinic area. For this reason, we kindly request that cell phones be turned off during treatment sessions.

Misc. Charges:

Some of the treatments you receive will require the use of supplies that are not reimbursable by insurance companies. Payment for these items will be expected at the time of treatment or they will be billed directly to you. Examples: electrodes, therabands and putty.

Payments:

Deductible, Co-Pay and/or Co-Insurance amounts are expected at each visit. Payment plans are available through the business office upon request.

Again, thank you for choosing Spinal Care Associates

Sheri Davenport, R.P.T.

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Edmond, OK 73034
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