SCORE Performance Medicine Intake Form

Workers' Compensation

Date:__________

Name: ____ DOB: _______________________ Circle: Male/Female

Address: ____________________________________City_________________________State__________Zip__________

Cell Phone: __________________________________ SSN: ____________________ Date of Injury: ____________

Emergency Contact Information: ____

Primary Care Doctor: __________________________ Referring Physician: ________________________________

Primary Health Insurance Company ____

ID # ____ Group # ______________________________

Is your insurance in your name: Yes / No

Subscriber Name ____ Subscriber SSN ________________________

Subscriber Address _________________________________City___________________State__________Zip__________

Subscriber Phone Number __________________________________ Subscriber Gender: Male / Female

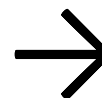
Subscriber DOB __________________ Subscriber Relation to Patient _____________________________________

Subscriber Employer ____

Subscriber Employer Address ________________________City___________________State__________Zip__________

Please present your insurance card(s) for photocopy

Please complete the attached form to establish authorization to treat



SCORE Performance Medicine

WORKERS' COMPENSATION INFORMATION

Patient Name: ______________________________

Employer Name: ______________________________

Employer Address: ______________________ City __________ State ______ Zip ______

Employer Phone Number: ______________________________

Worker's Comp Carrier: ______________________________

Carrier Address: ______________________ City __________ State ______ Zip ______

Carrier Phone Number: ______________________________

Case Manager Name: ______________________________

Case Manager Phone Number: ______________________________

DATE OF INJURY/ACCIDENT: ________________ BODY PART(S): ________________

CARRIER CASE #: ________________ WCB #: ________________

Disability Status: Are you currently working?

_____FULL DUTY _____LIGHT DUTY _____RESTRICTED DUTY _____NOT WORKING, date last worked________________

Job Description and Duties: ______________________________

____

Brief Description of Accident and what treatment you have had since that date: ______________________________

____

____

PATIENT TREATMENT WAIVER – WORKERS COMPENSATION

Thank you for choosing SCORE Performance Medicine for your Physical Therapy. We look forward to serving you and providing efficient, quality care. Since you have elected to treat with SCORE Performance Medicine for your injury you must be made aware of office policy. Should your Workers Compensation deny your claim, you are responsible for 100% of billed charges.

I, (print name)______________________________understand that the doctor does not participate with my private, backup insurance, or I do not have any. I understand and am aware of office policy regarding responsibility of medical bills. I have decided I wanted to continue with visits beginning today, and therefore assume responsibility for paying the bill.

____

Signature Date

____

Insurance Name

THIS FORM IS VALID FOR THE ENTIRE TREATMENT FOR THIS INJURY.

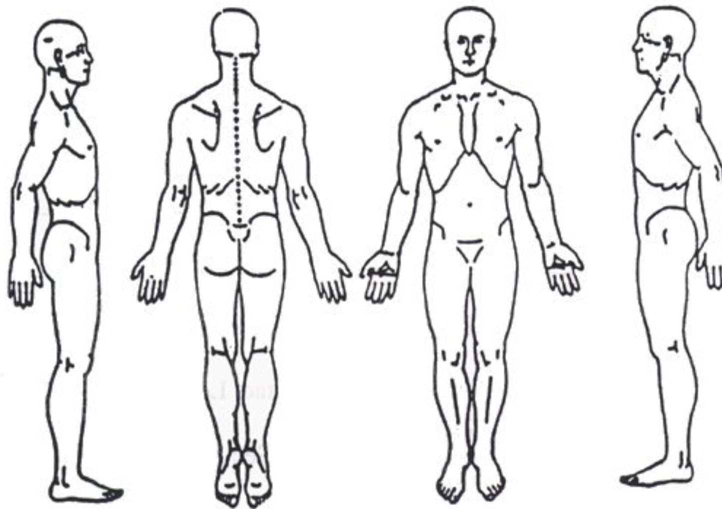
When and how were you injured?

What were the date of and results of any medical imaging and testing that you have had?

X Ray: ________________________________ CT Scan:_____________________________________

MRI: ________________________________ Other: ______________________________________

Please shade on this diagram where your pain and/or abnormal sensations are felt.



Please describe your pain in your own words (ie. dull, achy, sharp, throbbing, deep):

Please rate your pain over the last 2 weeks on this scale by circling the <u>lowest</u> (1), <u>current</u> (2), and <u>highest</u> (3) level of pain.

0 -1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 -10

Low range moderate pain range severe pain range

Medical History:

Please check any current medical conditions that you may have

Heart Attack/MI		Vascular Disease	
Cardiac Arrhythmia/Pacemaker		Open Wounds	
High Blood Pressure		Osteoporosis	
Coronary Artery Disease		Osteoarthritis	
Diabetes		Rheumatoid Arthritis	
Stroke CVA/TIA		Lupus/SLE	
Cancer		Multiple Sclerosis	
Epilepsy/Seizures		Parkinson's Disease	
Infectious Disease		Migraines	
Currently Pregnant		Fracture	
Vertigo		Location of Fracture(s):	

Please list

1) **Any other medical conditions that you have:**

2) **Past surgical history with the year surgery was performed:**

3) **Medications and supplements that you are taking:**

Have you experienced any of the following in the past month? (please check):

Recent bowl or bladder changes		Cancer History	
Abdominal Masses		Night sweats, Fever	
Unexplained tingling, numbness, weakness		Blood in Sputum/Coughing up blood	
Unexplained weight loss		Pain that is not able to be relieved	

Financial Policy
Appointment and Cancellation Policies

We are committed to providing you with the best possible care. We will gladly discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

Payment is due for services at the time services are rendered. This includes coinsurance, copayment, and deductible payments. If a check is returned for insufficient funds, you will be charged a bank fee in addition to the amount of the check.

After the insurance company has paid their portion of your claim, you are responsible for any unpaid charges on your bill. You will have 90 days to pay your bill before it is turned over to a collection agency. You will be responsible for any fees the collection agency charges.

I understand that my doctor has prescribed physical therapy, or I have chosen physical therapy without a doctor's referral. I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress.

I give my permission for SCORE Performance Medicine to provide information as needed to my insurance company.

Appointments: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival greater than 15 minutes may result in a shortened treatment or cancellation.

We require 24-hour notice of cancellation or a $25 fee may be assessed. You are directly responsible for this payment. Three episodes of absence from a physical therapy session without cancellation will result in discharge.

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Signature of patient or guardian (if minor) indicates acknowledgement and agreement of above

Patient Authorization for Use and Disclosure of Protected Health Information
Statement of Privacy Notice

We may disclose your health care information:

1. To other health care professionals within our practice for the purpose of treatment, payment, or health care operations
2. To your insurance provider for the purpose of payment or healthcare operations
3. To comply with State Worker's Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures
5. In the course of any administrative of judicial proceeding or law enforcement purposes

Under the HIPPA federal privacy law you have the right to:

1. Request restrictions on certain uses and disclosures of your health information
2. Inspect and copy your health care information
3. Receive an accounting or disclosure of your protected health information
4. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your health information.

If you have any questions regarding this notice of if you want more information about your privacy rights, please contact us at 716-302-3294.

My signature indicates my authorization and consent for SCORE Performance Medicine to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described above.

____

Patient's Name (print)

____

Patient's Signature