Continuum Wellness
Physical Therapy & Sports Rehab

WORKERS COMP. PATIENT DEMOGRAPHICS

Patient Name_____ Date: _____
Last First

Social Security #_____-_____-_____ Date of Birth_____/_____/_____

Address: _____

_____ _____ _____
City State Zip

Primary Phone # (_____)_____ Secondary Phone (_____)_____

Sex: F M Marital Status: Married Single Email _____

Employer: _____
Name Phone Number

_____
City State Zip Code

Emergency Contact: _____(_____)_____
Name Phone Number

Referring Care Physician:_____Phone:_____

Fax:_____

WORKMAN'S COMPENSATION:

Accident Date:_____

W/C Carrier_____Phone:_____Fax:_____

Claims Address: _____

_____

Adjuster:_____Phone:_____Fax:_____

Claim #_____ Case# (if different than claim#)_____

Nurse Case Manager:_____Phone:_____Fax:_____

I hereby authorize the treating Therapist and/or Continuum Wellness Clinic to release any information acquired in the course of my examination and/or treatment to my referring physician or insurance carrier(s) listed above. I hereby authorize Continuum Wellness to obtain; in my behalf any information covered by the "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to Continuum Wellness Clinic and/or its representatives for medical benefits.

Patient Signature_____ Date:_____

FOR OFFICE USE ONLY

**Start Date:_____ End Date_____ Authorized # of visits_____ Verified with:_____
Verified By:_____

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INITIAL PATIENT QUESTIONNAIRE

This questionnaire is designed to help us obtain necessary information about your health problems and activity level. Completing the form as completely as possible will help us to develop the most effective treatment program to meet your needs. If you have difficulties answering or understanding these questions, please ask for assistance.

NAME: _____ **Date:** _____

DOB/Age: _____ **Sex: M F Height** _____ **Weight** _____

What is your injury? _____

_____

Date of injury/onset of symptoms? _____

What is the mechanism/cause of injury? _____

Have you had previous treatment for this condition? Y N

If yes, what type of treatment? _____

Was there surgery? Y N **If so, what type of surgery?** _____

Date of surgery: _____

Where is your pain located? _____

Please indicate all symptoms:

___ Ache/Dull pain ___ Burning ___ Numbness

___ Other: please explain: ___ Spasm/Cramp ___ Pins & Needles ___ Stabbing/Sharp Pain

_____ ___ Stiffness ___ Shooting Pain ___ No pain

Please circle the numbers that indicate your pain level in the following categories. **Zero** indicates **no pain** and **ten** indicates the **worst** your symptoms have been.

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**

What increases your pain? _____

What activities, movements or treatments relieve your pain? _____

_____

PAST MEDICAL HISTORY

Please check if you experience any of the following:

___ Asthma	___ Diabetes	___ Lung Disease	___ Psoriasis
___ Allergies	___ Heart Disease	___ Gout	___ Rheumatoid Arthritis/Disease
___ Alcoholism	___ High Blood Pressure	___ Cancer	___ Seizure Disorder
___ Faintness	___ Difficulty Controlling	___ Osteoarthritis/	___ Lupus Erythematosis
	___ Bowel or bladder	___ Joint disease	

___ Muscle Weakness/Where? _____ ___ Numbness/Where? _____

___ Joint Pain/Where? _____ ___ Swelling/Where? _____

___Other _____

Current Medications Prescription/over the counter:

_____

_____

_____

Have you undergone any special testing recently Y N

If so, which ones: XRAY MRI CAT SCAN BONE SCAN Dates: _____

EMG EKG STRESS TEST INJECTION _____

Please list all surgeries in the last 5 years? _____

_____

WORK HISTORY

Current Work Status: ___Full-time ___Part-time ___ Light Duty ___ Not Working ___Unemployed

Where do you work? _____

What is your vocation/profession? _____

Briefly describe your tasks at work? _____

_____

Are you currently off work? Y N

When did you stop working? _____ **When do you return to work?** _____

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Authorization for Release of Protected Health Information

Patient Name: _____ Med Rec / Account #_____
Date of Birth: _____

I hereby authorize Provider to release information from my medical records to the following entity or persons:
Name: _____
Address: _____
Fax: _____ Email: _____

Please check type of information to be released:
- ☐ Entire Medical Record ☐ Registration Forms ☐ Billing / Financial Records
- ☐ Other (Specify) _____

Drug and/or Alcohol Abuse, and/or Mental Health, and/or HIV/AIDS Information Release
Please answer YES or NO to each of the following questions to indicate your permission for us to release the following information (if it is contained in your medical record):

Alcohol & Drug Abuse ☐**YES** ☐**NO**
Genetic Test Results ☐**YES** ☐**NO**
Domestic Violence Counseling ☐**YES** ☐**NO**
HIV/AIDS Test Results ☐**YES** ☐**NO**
Mental Health Diagnosis/Treatment ☐**YES** ☐**NO**
Sexual Assault Counseling ☐**YES** ☐**NO**

I understand that:
- I may withdraw my authorization at any time by submitting a written request to the Privacy Officer. My authorization may be withdrawn except for the following:
  - To the extent that action has been taken in reliance on this authorization.
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility benefits will not be affected.
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Provider.
- This authorization expires: ___ **1 year from date below** ___ **One time disclosure only** ___ **Other:**_____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____
Print Name: _____ **(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney (attach documentation)
☐ Other _____ (Explain and Attach Documentation)

Signature must be verified by Provider staff OR must be notarized. When completed, please place in patient record.

_____ _____ _____
Signature of staff member **Print Name** **Date**

SUBSCRIBED AND SWORN before me this _____day of _____, 20_____.
My commission expires:

_____
Notary Public Signature

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____
Clinic/Office: _____

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Date :_____

Patient Name: _____Med Rec # / Account#_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

Name of Authorized Individual	Relationship	Phone#
Name of Authorized Individual	Relationship	Phone#

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of the physician and therapist.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to provider for unpaid charges. I agree to pay provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent to allow provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:
Patients are encouraged to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on "hold" for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:
In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature: _____ Date: _____
Print Name: _____ **(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date :_____

Patient Name: _____Med Rec # / Account#_____

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: _____ Date: _____
Print Name:_____**(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)_____
_____

_____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____

Date:_____
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

□ **Patient refused to sign acknowledgement.**

□ **Patient was unable to sign the acknowledgement because:**
_____
_____

□ **Other reason (describe below):**
_____
_____
_____

Name of Employee Completing Form: _____

Signature:_____

Date: _____

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