

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ SSN: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Children: # of \_\_\_\_\_

Education: # of years completed: \_\_\_\_\_  Full-time student  Part-time student  Non-student

Exercise Habits:  Aerobic: Frequency \_\_\_\_/week Type: \_\_\_\_\_  Other: Frequency \_\_\_\_/week Type: \_\_\_\_\_

Dominant Hand:  Left  Right Corrective glasses/contacts:  Yes  No Implants/Devices:  Yes  No

Employed:  Full-time  Part-time  Retired  
 Work Status:  Working without restrictions  
 Working with restrictions, please list: \_\_\_\_\_  
 Not working/off work since \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Job Description: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Work Requirements:  Bend  Stoop  Stand  Walk  Climb  Sit  Crawl  Reach  Push  Pull  Kneel  
 Computer Work  Phone Work  Fine hand skills Lifting requirement: Max \_\_\_\_\_ lbs Repetitive \_\_\_\_\_ lbs

Address: \_\_\_\_\_  
Street Address/P.O. Box City State Zip

**Date of injury, surgery, or onset of symptoms:** \_\_\_\_\_

**What type of injury are we seeing you for?**  
 Auto  Sports Injury  No specific trauma  
 Work  Slip & Fall  Other

**Emergency Contact, not living with you:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

<b>Please provide the following information:</b>		<b>For Office Use Only</b>	
<input checked="" type="checkbox"/>	Copy of your Driver's License or Identification Card		
<input checked="" type="checkbox"/>	Copy of your Health Insurance Card		

**PATIENT'S HEALTH INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

**PATIENT PAIN PROFILE**

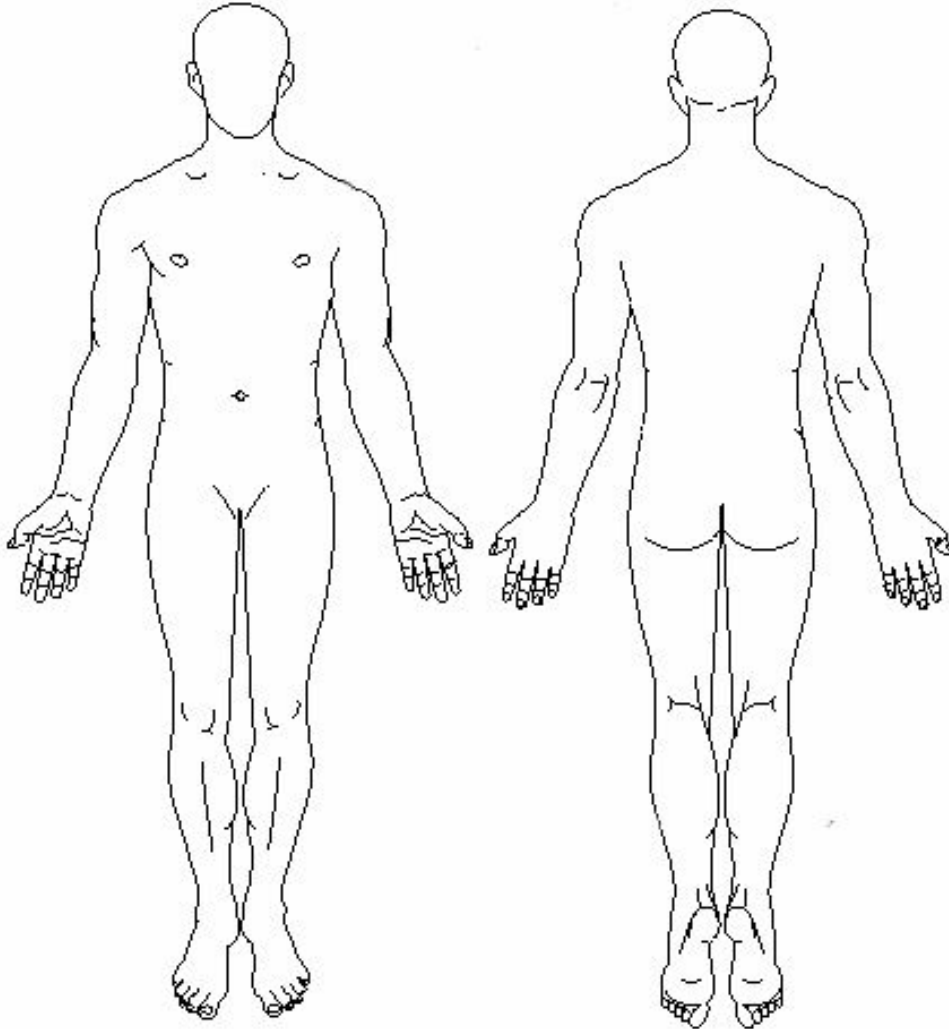
**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

**KEY**

A = ACHE    N = NUMBNESS    P = PINS & NEEDLES    B = BURNING    S = STABBING  
 O = OTHER (Please describe): \_\_\_\_\_



What percent of the time is your pain present? If your pain is there all the time, in varying degrees, that would indicate 100%.

Rate the intensity of your pain. Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you cannot perform or complete your work, social, or recreational activities.

	Symptom Description <i>Describe each symptom, including area, as clearly as possible.</i>	Frequency <i>Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours</i>	Intensity Range <i>Using a scale of 0-10, where 10 is the <u>worst</u> pain imaginable, rate the pain intensity level for each symptom.</i>
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

**FUNCTIONAL RATING INDEX – FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In order to properly assess your condition, we must understand how much **your neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please mark the number that most closely describes your condition right now.**

**SECTION 1 - Pain Intensity**

- ⓪ No pain
- ① Mild pain
- ② Moderate pain
- ③ Severe pain
- ④ Worst possible pain

**SECTION 2 - Sleeping**

- ⓪ Perfect sleep
- ① Mildly disturbed sleep
- ② Moderately disturbed sleep
- ③ Greatly disturbed sleep
- ④ Totally disturbed sleep

**SECTION 3 - Personal Care (washing, dressing, etc.)**

- ⓪ No pain; no restrictions
- ① Mild pain; no restrictions
- ② Moderate pain; need to go slowly
- ③ Moderate pain; need some assistance
- ④ Severe pain; need 100% assistance

**SECTION 4 - Travel (driving, etc.)**

- ⓪ No pain on long trips
- ① Mild pain on long trips
- ② Moderate pain on long trips
- ③ Moderate pain on short trips
- ④ Severe pain on short trips

**SECTION 5 - Work**

- ⓪ Can do usual work plus unlimited extra work
- ① Can do usual work; no extra work
- ② Can do 50% of usual work
- ③ Can do 25% of usual work
- ④ Cannot work

**SECTION 6 - Recreation**

- ⓪ Can do activities
- ① Can do most activities
- ② Can do some activities
- ③ Can do a few activities
- ④ Cannot do any activities

**SECTION 7 - Frequency of Pain**

- ⓪ No pain
- ① Occasional pain; 25% of the day
- ② Intermittent pain; 50% of the day
- ③ Frequent pain; 75% of the day
- ④ Constant pain; 100% of the day

**SECTION 8 - Lifting**

- ⓪ No pain with heavy weight
- ① Increased pain with heavy weight
- ② Increased pain with moderate weight
- ③ Increased pain with light weight
- ④ Increased pain with any weight

**SECTION 9 - Walking**

- ⓪ No pain; any distance
- ① Increased pain after 1 mile
- ② Increased pain after 1/2 mile
- ③ Increased pain after 1/4 mile
- ④ Increased pain with all walking

**SECTION 10 - Standing**

- ⓪ No pain after several hours
- ① Increased pain after several hours
- ② Increased pain after 1 hour
- ③ Increased pain after 1/2 hour
- ④ Increased pain with any standing

Score



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT HISTORY**

**Please LIST and DATE any type of test or treatment you have received:**

Name of Hospital: \_\_\_\_\_

X-rays: \_\_\_\_\_

CT Scan: \_\_\_\_\_

MRI: \_\_\_\_\_

Other diagnostic test: \_\_\_\_\_

Name of Urgent Care: \_\_\_\_\_

X-rays: \_\_\_\_\_

CT Scan: \_\_\_\_\_

MRI: \_\_\_\_\_

Other diagnostic test: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Name of Physical Therapy Clinic: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Name of Massage Therapy Clinic: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Name of Rehabilitation Clinic: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Exercise recommended: \_\_\_\_\_

Bracing/Splints: \_\_\_\_\_

Spinal manipulation/adjustments: \_\_\_\_\_

Heat packs: \_\_\_\_\_

Cold/ice packs: \_\_\_\_\_

Ultrasound: \_\_\_\_\_

Electrical muscle stimulation: \_\_\_\_\_

Other: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Other: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Other: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Other: \_\_\_\_\_

Treatment received: \_\_\_\_\_

Referrals prescribed: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

**Please list all known Allergies:**

Food: \_\_\_\_\_

\_\_\_\_\_

Airborne: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_



**FINANCIAL POLICY**

Welcome to our office! We are pleased that you have chosen Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage to provide your care and services. We would like to take a moment to inform you of our policies, regarding payment with the office. We accept cash, personal checks and credit card (VISA, MasterCard, American Express or Discover) for payment on your account.

PATIENTS WHO NEGLECT TO SUPPLY THIS OFFICE WITH THE NECESSARY INFORMATION/FORMS WITHIN A REASONABLE AMOUNT OF TIME **WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

**AUTO/PERSONAL INJURY INSURANCE** (PIP, Med-Pay, 3<sup>rd</sup> Party, Lien): You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full. If we are required to send your account to collections, the balance due on that date will be doubled and interest at the rate of 1.5% per month will also be added to the balance due, plus collection fees and reasonable attorney fees. If you have scheduled an appointment and do not cancel 24 hours prior to your appointment, you will be charged a \$50.00 no show fee. **Auto insurance/personal injury claims will not be billed under a general health or contracted insurance plan.**

**WORKER'S COMPENSATION:** You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

**CONTRACTED HEALTH INSURANCE** (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, and address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service, and any amounts not covered by your insurance, including co-insurance and deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for payment of the entire balance due, based on our normal fee schedule. **You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you reschedule or sign a waiver for no referral or authorization thus holding you financially responsible.**

**PRIVATE INSURANCE:** As a courtesy, we are happy to file your insurance for you. You will be required to provide all the necessary billing information. **If you owe on your deductible or a co-insurance, we will need to collect at the time of service.** All insurance payments that are paid directly to you should be endorsed and paid to Alliance Health Partners/Optima Rehabilitation. It is your responsibility to contact your insurance in the event of non-payment.

**MEDICARE:** We are participating with the Medicare program. *We will submit your claim/services to Medicare. Medicare will process payment to us.* You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us.

**CASH ONLY PLAN/NO INSURANCE:** *Payment in full is due the day services are rendered* by all patients on a cash only plan. *Prompt payment is expected.* Unless prior arrangements are made, overdue accounts will incur a 1.5% interest rate per month, plus collection fees and reasonable attorney fees.

***I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage.***

\_\_\_\_\_  
Patient's Signature (Responsible party over 18 years old)

\_\_\_\_\_  
Date

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_



**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION FOR A SPECIAL PURPOSE**

**1. Individual Patient (or personal representative) Confirming the Authorization**

I give authorization to use or disclose certain protected health information (PHI) about me as described below.  
 This authorization permits the use and/or disclosure of specific individually identifiable health information about me.

Patient's Legal Name (print): \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_  
 Patient's Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

**2. People or Organizations Authorized to Use and Disclose**

Physician or facility to **provide** records: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**3. People or Organizations Permitted to Use and Receive**

Person to **receive** records: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**4. Protected Health Information To Be Used And Or Disclosed**

Describe in detail the protected health information you are authorizing to be used and or disclosed:

\_\_\_\_\_

Laboratory tests and other diagnostic reports       All medical records at this facility

**5. Purposes of the Requested Uses and/or Disclosures**

The information will be used or disclosed for the following purposes: (at my request) \_\_\_\_\_

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

**6. Ending this Authorization - Select ONE of the Following:**

This authorization will expire on (Month/Day/Year) \_\_\_\_\_ .  
 This authorization will end when the following event happens. The event must be related to the individual or the purpose of the authorization us and for disclosure. Please describe the event: \_\_\_\_\_

**7. Changing your mind about this Authorization**

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer listed below. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.  
 Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage, 3920 N Union Blvd Ste 160, Colorado Springs CO 80907

**8. Signing this Authorization is not a Condition of Treatment**

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

**9. Signature**

I have had the chance to read and think about the contents of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations listed in this form.

Patient Name (print): \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date (Month/Day/Year): \_\_\_\_\_  
 If a personal representative for the individual patient signs this authorization, complete the following:  
 Representative's Name (print): \_\_\_\_\_ Relationship to the Individual Patient: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date (Month/Day/Year): \_\_\_\_\_