WORKER'S COMPENSATION PATIENT INFORMATION

DATE: / /		
NAME:		
DATE OF BIRTH:	SEX: M F	
SSN:	AGE:	
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE:	
EMPLOYER:		
ADDRESS		
CITY:	STATE:	ZIP:
OCCUPATION:	REFERRING MD:	
WHERE DID INJURY OCCUR (address)		
CITY:	STATE:	ZIP:
WORKERS COMP INSURANCE:		
ADDRESS:		
CITY:	STATE:	ZIP:
CLAIM NO.:	DATE OF INJURY:	
CLAIMS ADJUSTOR:		
PHONE:	FAX:	
UTILIZATION MANAGER:		
PHONE:	FAX:	
Do you have an attorney representing you in your case: yes no		
ATTORNEY NAME:		
ADDRESS		
CITY	STATE:	ZIP
PHONE	FAX:	

OFFICE USE ONLY: LIEN SENT ON:________________________

A.C.I.C. PHYSICAL THERAPY

Consent to Treatment & Therapeutic Procedures

I, ___________________________ hereby consent to the therapeutic procedures outlined below to be performed by A.C.I.C. Physical Therapy and their associates

I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions and/or pain. My results of the evaluation will be sent to my physician.

Updates in the form of a progress report will be done monthly, unless otherwise requested by the patient and/or physician, and sent to your physician.

I understand that treatment may include but are not limited to:

- Joint and soft tissue mobilization
- Clinic and home exercise programs including stretching, strengthening and balance/coordination exercises that you will be trained in.
- Functional retraining including posture and body mechanics
- Modalities such as heat, ice, electrical stimulation and ultrasound may be used to decrease pain/swelling.
- Special procedures such as taping and neuromuscular electrical stimulation
- Treatments will be delivered by a team of PT's, PT Assistants, PT Interns, and PT exercise specialists/aides.

I understand that I will be explained the purpose of the therapeutic procedures prior to receive treatment and that I may refuse any therapeutic procedure or treatment at any time.

I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I understand that no guarantees of a successful outcome have been given to me.

I understand that I can ask questions at any time regarding any aspect of my physical therapy care.

You should inform your physical therapist regarding any significant change in your symptoms, or activity e.g. before returning to sports, gym, etc.

Parents/guardians must attend all treatments unless otherwise agreed to, in writing. Minor patients will be supervised while in our offices, but not in public areas of the building complex.

I certify that I have read and understand the above consent statements:

Patient Name:______________________________

Patient's Signature:____________________________ Date:___________________
Parent or Authorized Representative (if applicable)

A.C.I.C. PHYSICAL THERAPY

Worker's Compensation Patient Agreement

Employer Notification:

Please be aware that when suffering a work-related injury or illness, the law requires that you notify you employer within 30 days of your accident/condition. Failure to report your accident/condition may result in you being responsible for all charges incurred in our office.

Patient Responsibility:

If you are notified by your Worker's Compensation carrier to go to a physician for examination other than your referring physician, you are responsible for notifying our office immediately for our records.

Our office will contact your Worker's Compensation adjustor for authorization of your physical therapy treatment.

Please be aware that we will need that prescription/order from your physician in order to request further authorization for continued physical therapy from your Workers' Compensation carrier. Be sure to bring the prescription or fax in to our office so that we can forward it on to the Nurse Case Manager on your case.

It is in your best interest to follow the recommended treatment plan given to you by your physician and physical therapist in order to achieve the maximum benefits for your condition. Continual missed appointments and/or noncompliance must be reported by us to both the referring physician and your Worker's Compensation adjustor. The Worker's Compensation laws state that if you choose not to receive care that is necessary for treatment of your condition, your Workers' Compensation benefits will be discontinued and your case will be closed at which point you will be responsible for payment of services to our office.

If authorization is denied you may be responsible for any charges incurred in our office.

_______ I have chosen to follow the policies of my health insurance company, ______________________________, if my Workers' Compensation claim is denied. I understand this choice makes me responsible for payment of all charges. I also understand that I am responsible for obtaining referrals and/or authorization if applicable

In order for you to start or continue physical therapy treatment under a lien, it must be agreed upon by our office at first notice of your Worker's Compensation carrier denying further care and/or denial of your case prior to the start of care..

I certify that I have read, understand and agree to adhere to the above policy:

Patient Name: ____________________________

Signature: _______________________________ Date: _______________________

A.C.I.C. PHYSICAL THERAPY

Patient Commitment & Missed Appointment Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits.

If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferable the very next day.

In an instance of cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $50 fee. The only exception to the cancellation fee is in the case of an emergency

If repeated non-compliance (cancellations and/or no-shows) with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

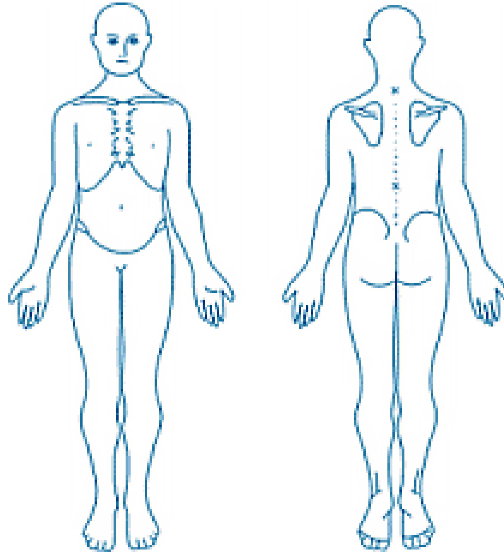
We greatly appreciate you as our patient and strive to accomplish wonderful results and success for you.

I certify that I have read, understand and agree to adhere to the above policy:

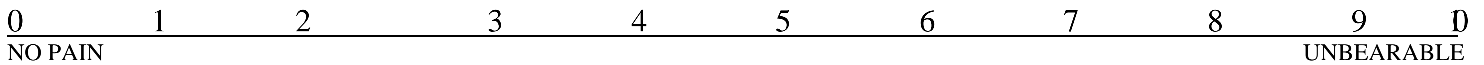
Patient Name: ____________________________

Signature: _______________________________ Date: _______________________

Please indicate on the body chart below, the location of your injury or condition. Also indicate the quality of your injury, condition, or pain (ie, ache, sharp, dull, weakness, shooting, etc.)



On a scale from 0 to 10, please indicate the range of your discomfort/pain (best to worst):



Symptoms are aggravated by:____

Symptoms are eased by:____

Symptoms are better in the: am______ pm______

Please check those activities that you are unable to perform since your injury / surgery and would like to resume.

Walking [ ]

Running [ ]

Going up / down stairs [ ]

Bending [ ]

Lifting [ ]

Sitting [ ]

Standing [ ]

Throwing [ ]

Reaching overhead [ ]

Other: _________________________

Activities of Daily Living:

Dressing [ ]

Grooming [ ]

Eating [ ]

Cleaning [ ]

Driving [ ]

Sports Activities:_______________________

MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: ______________________________ DATE: ______________________

CHIEF COMPLAINT:____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	yes ☐	no ☐	Hernia	yes ☐	no ☐
Balance Problems	yes ☐	no ☐	High Blood Pressure	yes ☐	no ☐
Circulatory Problems	yes ☐	no ☐	HIV / AIDS	yes ☐	no ☐
Diabetes	yes ☐	no ☐	Kidney Problems	yes ☐	no ☐
Dizzy Spells	yes ☐	no ☐	Nervous Disorder	yes ☐	no ☐
Headaches	yes ☐	no ☐	Pregnancy	yes ☐	no ☐
Hearing Problems	yes ☐	no ☐	Seizures	yes ☐	no ☐
Heart Attack	yes ☐	no ☐	Sensitive to heat / cold	yes ☐	no ☐
Heart Disease	yes ☐	no ☐	Vision Problems	yes ☐	no ☐

If yes on any of the above, please explain and give approximate dates of occurrences:
____
____

2. Have you had treatment for this / these problems before? Yes ☐ No ☐

If yes, where and when were you treated? ______________________________

3. Have you had surgery related to this / these problems? Yes ☐ No ☐

If yes, what type of surgery did you have and when was the surgery? ____________________

4. Do you currently have any metal implants? Yes ☐ No ☐

5. Do you currently have a pacemaker? Yes ☐ No ☐

6. Do you have any communicable diseases? Yes ☐ No ☐

7. List any medications you are currently taking:

____________________ ____________________

____________________ ____________________

____________________ ____________________

A.C.I.C. Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________________

Medical Record #: _______________

I hereby acknowledge that I have received a copy of A.C.I.C. Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_________________________________ _________________________
Patient Signature Date

_________________________________ _________________________
Representative Signature (if applicable) Relationship to Patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _______________________ but acknowledgement could not be obtained for the following reason(s):

_________ Patient / Patient Representative refused to sign

_________ Emergency situation prevented us from obtaining acknowledgement at this time, will attempt at a later date

_________ Communication barriers prohibit obtaining acknowledgement. (explain):
____
____

________ Other (specify)
____
____

ACIC Representative: ________________________________