WEST COAST SPINE
RESTORATION CENTER

Is your therapy related to one of the following?
If yes, whom should we bill?

Yes or No: Auto Accident

- ☐ **Auto Insurance**
- ☐ **Lien**
- ☐ **Medical Insurance**

YeS or No: Worker's Compensation

Reported to employer ☐**Yes** ☐**No**

Claim # _____

Yes or No: Personal Injury (i.e. slip and fall)

- ☐ **Lien**
- ☐ **Medical Insurance**

Print Name: _____ **DOB:** _____

Date: _____ **Signature:** _____

(951) 653-4480 • FAX (951) 653-5051 • 6177 River Crest Dr., Suite A, Riverside, CA 92507
Website: www.westcoastspine.com

PLEASE PRINT

DATE: _____

NAME: _____ MI _____ BIRTHDATE _____
Last Name First Name

ADDRESS: _____ ZIP _____
Street Number City, State

PHONE#: ( ) _____ CELL #: ( ) _____ SEX _____

SINGLE/ MARRIED/ DIVORCE/ WIDOW SS# _____ DATE OF INJURY _____
Circle One

WORK RELATED: YES / NO **AUTO ACCIDENT**: YES / NO

EMPLOYER

_____
Name

_____
Address

_____
City, State, Zip

PHONE ( ) _____

DOCTOR

_____
Name

_____
Address

_____
City, State, Zip

PHONE ( ) _____

WORK COMP INSURANCE

_____
Name

_____
Address

_____
City, State, Zip

CLAIM# _____

ADJUSTER NAME: _____

PHONE ( ) _____

PRIMARY INSURANCE (Copy of card will be made)

_____
Name

ID #: _____

_____

PHONE ( ) _____

CO-PAYMENT AMOUNT: _____

ATTORNEY

_____
Name

_____
Address

_____
City, State, Zip

PHONE ( ) _____

EMERGENCY CONTACT:

_____
Name

PHONE ( ) _____

_____
Name

PHONE ( ) _____

Financial Responsibility Agreement

RESPONSIBILITY FOR PAYMENT:

By signing below, I understand that I am responsible for payment for all services provided to me by West Coast Spine Restoration Center and/or West Coast Spine and Sports Therapy Center (WCS)

As a courtesy WCS verifies my eligibility and benefits prior to start of therapy and bills my insurance company as a courtesy. It is my responsibility to independently verify this with my insurance company and I am actually responsible to obtain insurance payment. If I am not the patient, I understand that by signing below, I am personally responsible for all fees incurred by the patient.

I am responsible for meeting and paying my annual deductible and the designated co-payment/co-insurance amounts. I understand that I am responsible for payment whether there is any applicable insurance coverage or not.

Fees are due on the date of service is provided. Interest will accrue at 1.5% monthly (18% annually) on any unpaid fees commencing on the date of service. In addition, a one time deliquency fee equal to 15% if the unpaid balance shall be due on any unpaid balance assigned to a collection agency. Any unpaid balance may be assigned for collection to a collection agency at any time at WCS's sole discretion. If legal proceedings are started to collect any unpaid balance, I will additionally be responsible for any attorney fees and court costs incurred by WCS.

I have read and understood the above and I have no questions regarding payment terms. _____
Date

_____ _____
Signature of Paitent and Financially Responsbile Party or Financially Responsible Party if not the Patient

Print Patient Name

WEST COAST SPINE
RESTORATION CENTER

To All Medicare Patients:

1. Have you **ever** been enrolled in a Home Health Agency for anything or any services? **(i.e. therapy, psychology, home cleaning, hospice etc.)** Agency name: _____
   Yes ____ No ____ Agency Phone: _____

2. Will you be enrolling in a Home Health Agency for anything or any services? **(i.e. therapy, psychology, home cleaning, hospice etc.)** Agency name: _____
   Yes ____ No ____ Agency Phone: _____

3. **Please Note: If you are enrolled in Home Health Care for <u>any</u> services, Medicare <u>will</u> <u>not</u> pay your bill, and you will be responsible for your bill in full here at West Coast Spine.**

Due to the new Medicare Guidelines it is imperative that you <u>see your physician ever 30 days for him/her to update or provide you with a new prescription.</u>

We do not want you to have an interruption in treatment.

Thank you

_____ _____
Patient signature Date

Verified by: _____

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Authorization for Release of Medical Records

In accordance with California Assembly Bill 610, I _____ hereby authorize West Coast Spine Restoration Center and/or West Coast Spine and Sports Therapy Center , 6177 River Crest Drive, Suite A, Riverside, CA, 92507 and/or 6814 Magnolia Avenue, Riverside, CA, 92506 to release a copy of my complete medical records for all dates of service for Physical/Occupational/Speech Therapy including billing to:

_____

_____

_____

There is no expiration date for this authorization. I understand that I can revoke this authorization at any time by notifying the above company in writing. I understand that the revocation will not apply to information that has been released in response to this authorization.

_____ _____

Signature of patient or authorized Legal Guardian, Heath Care Agent, or other authorized Personal Representative — Patient Date of Birth

_____ _____

If signed by a Legal Representative, relationship to patient — Date

****

Autorización para la Divulgación de expedientes médicos

De conformidad con la California Assembly Bill 610, que _____ la presente autorizo al West Coast Spine Restoration Center o de West Coast Spine and Sports Therapy Center, 6177 River Crest Drive, Suite A, Riverside, CA 92507 o 6814 Magnolia Avenue, Riverside, CA 92506 para liberar una copia completa de mi historial médico para todas las fechas de los servicios de terapia física/ocupacional/del habla, incluida la facturación de:

_____

_____

_____

No hay fecha de caducidad de esta autorización. Entiendo que puedo revocar esta authoriztion en cualquier momento mediante notificación a la empresa mencionada en el escrito. Entiendo que la revocación no se aplicará a la información que ha sido lanzado en respuesta a esta authoriztion.

_____ _____

La Firma Del Paciente o Tutor Legal Autorizado, Agente de Atención Médica, U Otro Representante Personal Autorizado. — Fecha de Nacimiento del paciente

_____ _____

Si es Firmado Por el Representante Legal, Relación Con el Paciente. — Fecha

WEST COAST SPINE
RESTORATION CENTER

Dear Patient,

West coast spine and your therapist will accommodate your schedule as much as possible for appointments. We realize <u>your time</u> is as precious as <u>ours</u>.

Therefore, we ask you to please cancel if you cannot keep your appointment. We would appreciate 24 hour notice if possible.

Thank you.

Administration

_____ _____

Patient/Parent/Guardian Signature Date

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WEST COAST SPINE
RESTORATION CENTER

SUPPLIES

Dear Patient,

As a courtesy to our patients, we bill your insurance and in some cases, retrieve the authorization if needed on supplies, but in the event the supply you receive is *not* a covered item by your insurance company, you will be responsible for the payment.

Thank you.

Administration

_____ _____

Patient Signature **Date**

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WEST COAST SPINE
RESTORATION CENTER

INFORMED CONSENT FOR PHYSICAL/OCCUPATIONAL/SPEECH THERAPY

Dear Patient,

Physical therapy involves the use of many different types of physical evaluation and treatment. At West Coast Spine Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercise, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by West Coast Spine Physical Therapy, and I have had the opportunity to ask questions. I understand the risks and benefits associated with the program of Physical Therapy as outlined to me, and I wish to proceed.

Patient Name	Patient Signature	Date

Past Medical History

Other health problems may affect your treatment. Please check (✔) any of the following that apply to you:

____ Arthritis
____Osteoporosis
____Asthma
____Chronic Obstructive Pulmonary Disease (COPD)
____Aquired Respiratory Distress Syndrome (ARDS)
____Emphysema
____Angina (heart or chest pain)
____Congestive heart failure, heart disease
____Heart Attach (myocardial infarction)
____Pacemaker
____High blood pressure
____Neurological Disease (Multiple Sclerosis, Parkinson's)
____Seizures, epilepsy
____Stroke or TIA
____Peripheral Vascular Disease
____Dizziness/Vertigo
____Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
____Cancer
____Previous accidents
____Allergies
____Incontinence
____Anxiety or Panic disorders
____ Depression
____Hepatitis /AIDS
____Prior surgery
____Prosthesis, metal implants
____Sleep dysfunction
____Tuberculosis
____Pregnant
____Current smoker
____Visual impairment (cataracts, glaucoma, macular degeneration)
____Kidney, bladder, prostate or urination problems
____Back pain (neck, low back, spinal stenosis, degenerative disc disease)
____Headaches
____Diabetes Types I or II
____Other conditions / Disorders

Patient Signature: _____ Date: _____

Signature below reflects that the evaluating therapist reviewed and discussed any past medical history with the patient.

Therapist Signature: _____ Therapist Name: _____

Please explain what medications you are currently taking and for what conditions:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

**_____ See attached medication list

Hand Dominance: _____ Right _____Left

Work History

What is/was your job title: _____

Which work tasks effect your pain: _____

_____

Are you currently working? _____Yes _____No

_____ Full Time _____ Part Time _____ Full Duty _____ Modified Duties

History

Please describe how you were injured _____

_____

_____

If this problem is not injury related, how long have you had your current symptoms and what is the cause of your condition? _____

_____

Have you had previous physical or occupational therapy for your current problem?

_____Yes _____No

Was your treatment successful? _____Yes _____No

What do you hope to gain or achieve with physical / occpational therapy treatments?

_____

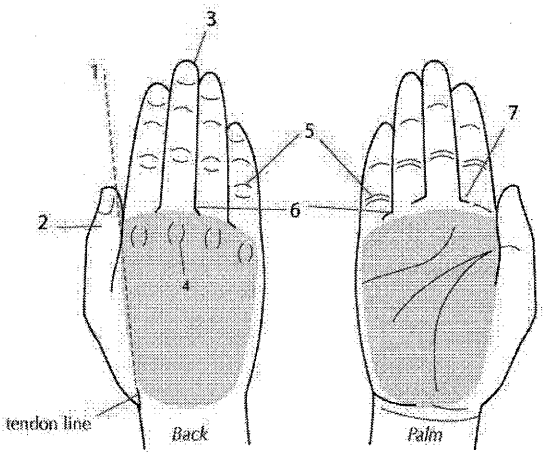
_____

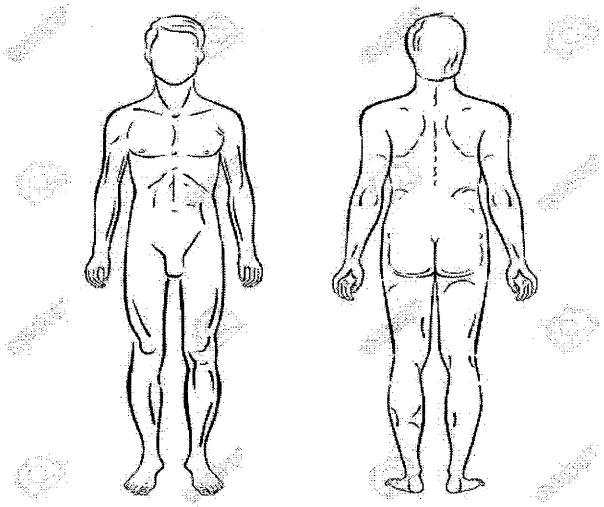
_____ _____

Patient Signature Date

PAIN QUESTIONARE

Indicate your symptoms on the diagrams using the symbols in the key.





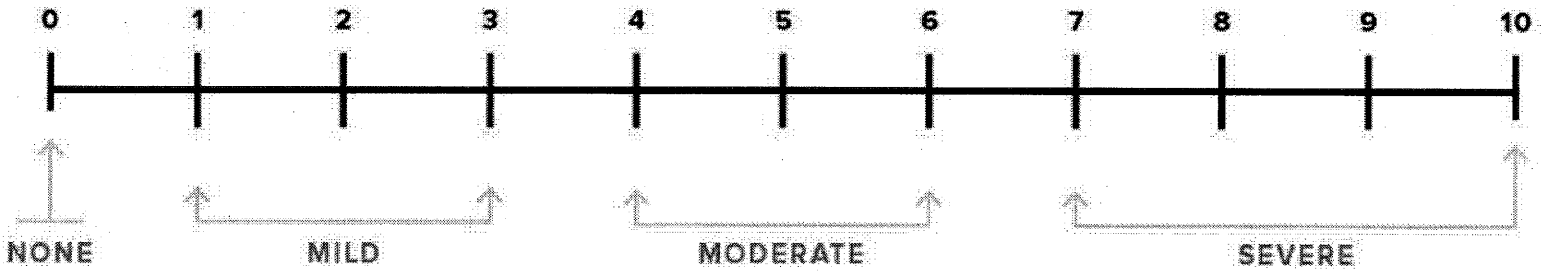
Top **Palm**

KEY

//// Stabbing XXX Burning 000 Pins and Needles ==== Numbness

Other despcriptions _____

PAIN RATING



Choose the number that best describes the severity of your pain.

Average Pain Level _____
At its Best _____
At its worst _____

Is your pain? Constant _____ **or Intermittent** _____

Does standing, walking or sitting effect your pain? ❒ Yes or ❒ No
If yes, please answer the following:

	Minutes	Hours	Unlimited
How long can you stand prior to increased pain?	_____	_____	_____
How long can you sit prior to increased pain?	_____	_____	_____
How long can you walk prior to increased pain?	_____	_____	_____
How long can you grip an object?	_____	_____	_____
Can you reach overhead with right arm?	_____	_____	_____
Can you reach overhead with left?	_____	_____	_____

1. **Please indicate the number of surgeries for your primary condition:**

   ____None ____ 1 ____2 ____3 ____4 or _____more

2. **How many days ago did the condition begin?**

   _____ 0-7 days _____8-14 days _____15-21 days

   _____ 22-90 days _____91+ days

3. **Are you taking prescription medication for this condition? _____ Yes ____No**
4. **Have you received treatments for this condition before? _____ Yes ____No**
5. **How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?**

   ____ At least 3 times weekly

   ____ Once or twice a week

   ____ Seldom or never

6. **This is a statement other patients have made. "I should not do physical activities which (might) make my pain worse." Please rate your level of agreement with this statement below.**
   (Circle a number)

   0 1 2 3 4 5 6

   Completely disagree Unsure Completely agree

Dear Patients,

After your initial evaluation, you may be assigned to a different therapist for your treatments, depending on your time schedule and availability.

Thank you for your understanding.

_____ _____

Patient Signature Date