



# WORKER'S COMPENSATION PROGRESS PHYSICAL THERAPY REFERRAL



Center Number _____	Center Name _____	Date Taken _____		Taken By _____	
Account / Reg# _____	Appointment Date _____	Time _____	Transportation ( <i>Circle One</i> ) Y N		
Therapy [ <i>Circle One</i> ]	PT	OT	Work Harding	FCE	Job Analysis

PATIENT INFORMATION [ Initial intake by Center ]

**\*\*First Name** \_\_\_\_\_ MI \_\_\_\_\_ **\*\*Last Name** \_\_\_\_\_

**\*\*Date of Birth** \_\_\_\_\_ Gender [*Circle One*] M F SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**\*\*Mailing Address \*\*[Street]** \_\_\_\_\_  
**\*\*[City]** \_\_\_\_\_ **\*\*[State]** \_\_\_\_\_ **\*\*[Zip Code]** \_\_\_\_\_

Physical Address [Street] \_\_\_\_\_  
 same [City] \_\_\_\_\_ [State] \_\_\_\_\_ [Zip Code] \_\_\_\_\_

**\*\*Home Phone** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ **\*\*Work Phone** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

**\*\*Cell Phone** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

**Employer 'Where Injury Occurred'**

**\*\*Employer Name** \_\_\_\_\_ **\*\*Employer Contact** \_\_\_\_\_

**\*\*Employer Phone Number** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

**Current Employer**

Employer Name \_\_\_\_\_ Employer Contact Name \_\_\_\_\_

Employer Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Injured Area of Body \_\_\_\_\_ Date of Injury \_\_\_\_\_

**\*\*Worker's Comp. Ins. Co.** \_\_\_\_\_ **\*\*Claim #** \_\_\_\_\_

W/C Billing [Street]/[PO Box] \_\_\_\_\_ [City] \_\_\_\_\_ [State] \_\_\_\_\_ [Zip] \_\_\_\_\_

W/C Insurance Company Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Adjuster Name \_\_\_\_\_

**\*\*Personal Health Ins. Company** \_\_\_\_\_ Effective Date \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured / Relationship \_\_\_\_\_ DOB-[subscriber] \_\_\_\_\_

**\*\*Ins. ID#** \_\_\_\_\_ Group# \_\_\_\_\_ CO-PAY \$ \_\_\_\_\_

Phone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Primary Physician \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Benefits \_\_\_\_\_

**\*\*Attorney Name** \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

**\*\*Referring Physician** \_\_\_\_\_ Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

How did you hear about our company? (*Circle One*)

Doctor Lawyer Friend / Family Employer Phone Book Ad  
Other \_\_\_\_\_

My signature below states that I have reviewed the information above and the information is true and correct .My injury is a result of a "Work Related" incident.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

*Our Goal is for you to have a DYNAMIC experience—Thank You for choosing Progress Physical Therapy*

# PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

DATE: \_\_\_\_\_

## PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please check if you have had problems with or are presently complaining of any of the following:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Unexplained weight gain/loss
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis or jaundice
<input type="checkbox"/> Cancer	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Headache
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Difficulty urinating
<input type="checkbox"/> Chest pain / Chest tightness	<input type="checkbox"/> T.B.	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Nausea	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Gout
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> HIV
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Balance Deficits
<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Amputation	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Loss of use of body region	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Other

## PAST SURGICAL HISTORY

Please list all surgeries, include date, you have had, related or unrelated to current problem

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## CURRENT MEDICATIONS Please list all current medications, related or unrelated to current problem.

Write down next to the medication what it is for.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_



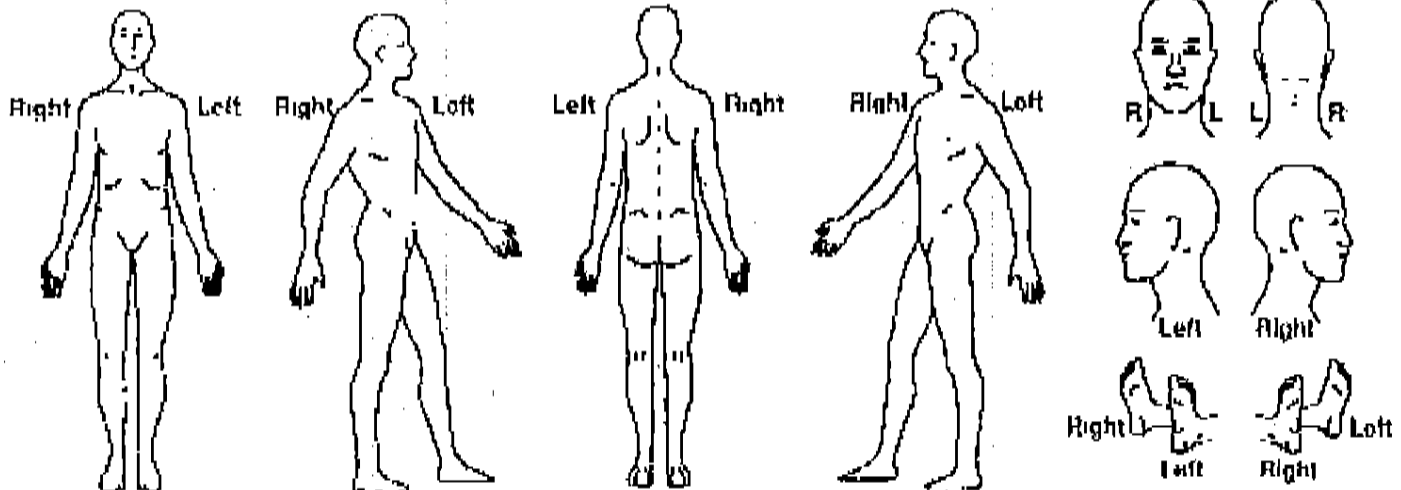
# PROGRESS PT

CENTERS FOR FITNESS AND REHABILITATION

DATE: \_\_\_\_\_

## PRESENT COMPLAINTS

- Circle the region(s) where you are experiencing pain or a problem right now.
- Place a number in each circle from the pain scale below.



\_\_\_\_\_ Your pain at it's BEST

\_\_\_\_\_ Your pain at it's WORST

- 0 – No pain at all
- 1 – Very mild
- 2 – Mild
- 3 – Bothersome
- 4 – Moderate
- 5 – Able to complete daily routine

- 6 – Unable to complete daily routine
- 7 – Unable to do anything, but rest
- 8 – Considering going to the hospital
- 9 – Going to the hospital
- 10 – Calling 911, excruciating

I authorize payment of medial benefits to PROGRESS PT Centers for Fitness and Rehabilitation for all care provided by the aforementioned facility or its employees.

Authorized person's signature \_\_\_\_\_

I authorize the release of any medical or other information necessary to process all medical claims. I also request payment of government benefits either to myself or to PROGRESS PT Centers for Fitness and Rehabilitation.

Authorized person's signature \_\_\_\_\_

**PROGRESS PT**  
**CENTERS FOR FITNESS AND REHABILITATION**

I, \_\_\_\_\_, understand that I am solely  
Patient Name  
responsible for payment of all bills for services rendered for all  
treatment provided by Progress PT for injuries sustained on:

\_\_\_\_\_  
Date of Accident

Regardless of the outcome of settlement of my case, Progress PT can  
hold me solely responsible for all charges.

My signature below is proof of agreement to the above statement.

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

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PROGRESS PT**  
CENTERS FOR FITNESS AND REHABILITATION

**AUTHORIZATION FOR MEDICAL RECORDS RELEASE**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ SSI #: \_\_\_\_\_

This is a formal request to have the aforementioned patient's records released from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The records we are requesting to be released are:

\_\_\_\_\_  
\_\_\_\_\_

These records are to be forwarded to:

***Progress PT Centers for Fitness and Rehabilitation  
283 Second Street Pike, Ste. 145  
Southampton, PA 18966  
Phone: (215)-494-2255 / fax: (215)-494-2258***

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

This authorization will be valid for six months from date of signing. The request may be revoked by the aforementioned patient or legal guardian by written request only.

CENTERS FOR FITNESS AND REHABILITATION  
**PROGRESS**  
 PHYSICAL THERAPY

**New Patient Consent to the Use and Disclosure of Health Information  
 for Treatment, Payment, or Healthcare Operations**

I, \_\_\_\_\_, understand that as part of my health care, PROGRESS PT originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Description of the information to be used or disclosed (check all that apply):

- The patient's partial or entire medical record  
 (NOTE: This requires an explanation why the entire record may be disclosed).
- The patient's demographic information (check all that apply):
  - Name  Address  State/Zip Code only  Telephone
  - Age  Gender  Race  Other: \_\_\_\_\_

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In the event that you are unavailable to be reached, and would like us to leave a message for you, please place a check acceptable ways to notify you (check all that apply):

- Answering Machine
- Family member
- Friend

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

\_\_\_\_\_

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, PROGRESS PT must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

PROGRESS PT will accept written revocations of this authorization via:

1. Certified U.S. mail or
2. Facsimile at this number: 215-744-7394.

ALL revocations must be sent to PROGRESS PT to the attention of the Privacy Officer, William Leitzel, and are not effective until received by the Privacy Officer.

CENTERS FOR BUSINESS AND REHABILITATION  
**PROGRESS**  
 PHYSICAL THERAPY

I understand that PROGRESS PT is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that PROGRESS PT reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should PROGRESS PT change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I fully understand and accept / decline the terms of this consent.

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: \_\_\_\_\_

Witnesses by: \_\_\_\_\_

\_\_\_\_\_  
 FOR OFFICE USE ONLY

Consent refused by patient, and treatment refused as permitted.

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): \_\_\_\_\_

By: (name and title): \_\_\_\_\_