Ortho Packet

littlefield therapy

phone/fax: (855) 454-3784

www.littlefieldpt.com

Patient Intake Form		
Patient Name: (Last, First, Middle Initial)	DOB:	Sex:
Address:	City, State:	Zip:
Primary Phone:	Secondary Phone:	Email:
Parent/Legal Guardian:	Relationship to Patient:	
Parent/Legal Guardian:	Relationship to Patient:	
If applicable, Service Coordinator:		
Physician Information		
Referring Physician:	Primary Physician, if different than referring:	
Address:	City, State:	Zip:
Phone:	Fax:	Medical Diagnosis:
Insurance Information/Responsible Party		
Primary Insurance Company:	Member ID Number:	Phone Number:
Secondary Insurance Company:	Member ID Number:	Phone Number:
Medical Group (IPA) HMO's only:	Provider Services Phone:	Provider Services Fax:
Primary Insured Name: (Last, First, Middle Initial)	DOB:	SSN:

Patient Name _____ Signature _____ Relationship to Patient _____ Date _____

1171 S. Sanderson Ave.
Suite 102
Hemet, CA 92545

41421 Date Street
Suite 101
Murrieta, CA 92562

27525 Enterprise Circle West
Suite 101-C
Temecula, CA 92590

32401 Temecula Parkway
Temecula, CA 92590

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Release of Information

This authorizes, Littlefield Physical Therapy Inc., to provide a copy, summary or narrative of medical records and for the release of information (verbal, telephone contact, written evaluations, progress reports, medical reports and/or medical evaluations) regarding (Patient) _____, from today ____/____/____ through discharge. Unless otherwise specified. I authorize the release of information between Littlefield Physical Therapy Inc. and:

Please list any and all that apply otherwise information may not be released.

Parent/Legal Guardian:
Additional Family Members:
Nurse/Caretaker:
Primary Physician:
Specialist:
Insurance Company:
Regional Center:
CCS representative:
DME (durable medical equipment) vendor:
Orthosis:
Other:

Please list any individuals we are legally not allowed to release information to and attach documentation:

Name/s:

_____ _____ _____

Signature Relationship to Patient Date

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OFFICE POLICIES

Thank you for choosing Littlefield Physical Therapy. We take your health and trust in us very seriously.

- **CONSENT FOR TREATMENT:** The undersigned does hereby authorize Littlefield Physical Therapy, Inc. consent to evaluate and/or provide medical treatment for the below mentioned patient by employees of Littlefield Physical Therapy, Inc.
- **ARRIVAL:** Upon your early arrival please sign-in and feel free to get started with exercises and activities in our facility. Therapy session are scheduled for 30-60 minutes long. **A 10 minute grace period after the scheduled appointment time is given.** Any arrivals beyond the 10 minute allowance will count as a no show.
- **PARTICIPATION:** Your participation and consistency in maintaining all scheduled appointments is critical to your rehabilitation and success. We enjoy keeping open lines of communication therefore should you have questions please bring them up with your therapist at the beginning of your session. *Please be advised that parents/guardians of children less than 16 years of age must stay on the premises during your child's treatment session***.**
- **SCHEDULING**: We make every attempt to accommodate your preferences. We encourage you to speak to our staff regarding scheduling needs. Please allow a minimum of 24-hour notice for cancellations. **After 3 last-minute cancellations/no shows in a 90 day period the client will be moved to a flexible or same day schedule.**
- **ILLNESS:** If your child presents with an illness preventing him/her to attend day care/school or participate in activities, you will be asked to reschedule their appointment. (See back for details).
- **REFERRALS:** A doctor's referral for Physical, Occupational, and Speech Therapy is necessary in most cases. Please speak with your physician regularly regarding therapy and assistance in attaining new or modified referrals every six months or as requested by your insurance. We are happy to assist you in attaining a referral if you are having difficulty.
- **AUTHORIZATION OF PAYMENT:** Patients are responsible for the reimbursement of therapy sessions. I agree to pay the applicable co-pays, co-insurances and deductibles at the time of service unless other arrangements have been made. It is the patient's responsibility to know their insurance coverage. Patients should ensure necessary authorizations are obtained and are encouraged to work with Littlefield Physical Therapy, Inc. regarding any reimbursement issues.
    - For non-sufficient funds/returned checks, Littlefield Physical Therapy will charge a **$25.00 fee** per item.
- **LIABILITY:** I know and agree that Littlefield Physical Therapy, Inc. is not responsible for lost or damaged personal items.

I would like a copy of the Privacy Practice, Health Insurance Accountability Act (HIPAA) regulations notice. YES / NO (Circle One)
By my signature, I acknowledge that I have read, understand, and agree to the Office Policies of Littlefield Therapy.

_____	_____	_____	_____
Patient Name	Signature	Relationship to Patient	Date

***We are committed to the future excellence of therapists. Consequently, interns, students and volunteers participate in our sessions. Please speak with your therapist if you are concerned with student and/or volunteer involvement.*

***Melissa Littlefield is the sole owner of Littlefield Physical Therapy. In keeping with ethical standards we do not endorse POPTS (Physician Owned Physical Therapy Services). Any questions or concerns can be directed to Melissa Littlefield.*

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SICK POLICY

In order to ensure the health of yourself and other patients we serve, we request that patients cancel their therapy sessions for the following communicable illnesses as soon as symptoms appear. Any illness preventing you to attend work or participate in activities including one or more of the following conditions:

- Fever of 100 degrees or over, within 24 hours of a visit
- Vomiting or diarrhea within 24 hours of a visit
- Contagious Conditions: Influenza (flu), Cold, Pink eye, Head lice, Rashes

This policy also applies to family members in the waiting area of our clinic. If you are unsure if your condition is contagious, please consult your doctor before the therapy session. Although some illnesses seem less severe than others, they can be detrimental to our medically fragile patient population. If you need a doctor's note to return to work, we kindly request that you provide one for their medical record as well.

By my signature, I acknowledge that I have read, understand, and agree to the Sick Policy of Littlefield Therapy.

Patient Name	Signature	Relationship to Patient	Date

**Effective 11/1/2016

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PHOTO RELEASE

For good and valuable consideration, the receipt of which is hereby acknowledged,

I _____, hereby authorize Littlefield Physical Therapy permission to use myself in a photograph/video in any and all of its publications, including but not limited to all Littlefield Physical Therapy printed and digital publications. I understand and agree that any photograph of myself will become property of Littlefield Physical Therapy and will not be returned.

I acknowledge that since my participation with Littlefield Physical Therapy is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize Littlefield Physical Therapy to edit, alter, copy, exhibit, publish or distribute this photo/video for purposes of publicizing Littlefield Physical Therapy's program or for any other related, lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, where the photography/video appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Littlefield Physical Therapy from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

Print Client's Name: _____ Date:_____

Client's Signature: _____Date:_____

(*Signature of parent/guardian if under 18 years of age)*

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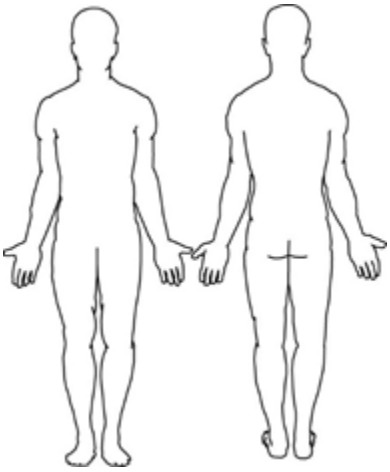

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

Describe your current Problem and how it began:

_____

_____

_____

Is this? □ Work Related □ Auto Related □ N/A

Date problem began: _____

Current complaint (how you feel today):

|_____|

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Can you perform your daily activities? □ Yes □ No

(Describe): _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? □ No □ Yes Date(s) Taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: □ None Apply

No	Yes	Condition	No	Yes	Condition
□	□	History of Recent Infection	□	□	Prostate Problems
□	□	Recent Fever	□	□	Frequent Urination
□	□	HIV/AIDS	□	□	Pregnancy, # of births _____
□	□	Diabetes	□	□	Abnormal Weight □ Gain □ Loss
□	□	Corticosteroid Use	□	□	Epilepsy/Seizures
□	□	Birth Control Pills	□	□	Visual Disturbances
□	□	High Blood Pressure	□	□	History of Low/Mid Back Pain
□	□	Stroke (Date) _____	□	□	History of Neck Pain
□	□	Dizziness/Fainting	□	□	Arthritis
□	□	Numbness in Groin/Buttocks	□	□	History of Alcohol Use
□	□	Urinary Retention	□	□	History of Tobacco Use
□	□	Aortic Aneurysm	□	□	Surgeries/Medications: _____
□	□	Cancer/Tumor			_____
□	□	Osteoporosis			
□	□	Recent Trauma			

Family History: □ Cancer □ Diabetes □ High Blood Pressure □Cardiovascular Problems/Stroke

_____ _____ _____

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