Close physical therapy

Physical Therapy and Rehabilitation Centers

PATIENT INFORMATION:

DATE_____

NAME_____
Last First M.I.

ADDRESS_____
Street City State Zip Code

HOME PHONE_____CELL PHONE_____DOB: _____ SS#_____

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME_____PHONE_____ RELATIONSHIP:_____

REFERRING PHYSICIAN_____DATE OF INJURY OR ILLNESS_____

TYPE OF INJURY: ☐ work ☐ auto ☐ sports ☐ other BODY PART (S)_____

****MEDICARE PATIENTS**: HAVE YOU RECIEVED HOME HEALTH WITHIN THE PASS 6 MONTHS?

YES___ NO_____ IF YES: NAME OF COMPANY_____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID #_____ Name of insured_____

SECONDARY INSURANCE _____ ID#_____ Name of insured_____

Cancellation/No-show:

I understand that if I do not show up for my scheduled appointment or do not call to cancel my appointment within 24 hours or in a timely manner, I will be charged a $25 fee. **The patient is responsible for paying the fee NOT THE INSURANCE.**
Initial_____

HIPAA:

***Initial to acknowledge that you have read and understood our Notice of Privacy Practices _____

AUTHORIZATION AND RELEASE

I authorize Close Physical Therapy to release my medical records to the referring physician and to bill my insurance company. I authorize my insurance company to pay Close Physical Therapy directly. **If my insurance company do not pay, I will be responsible for all services rendered.**

X_____DATE_____

SERVING LAS VEGAS FOR OVER 40 YEARS

PATIENT MEDICATION LIST

Patient Name:

Date:

Medication	Dosage	Times/day

Close physical therapy

Physical Therapy and Rehabilitation Centers

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Patient ID#: _____

Date of Service: _____

Service: Physical Therapy

Before your bills can be processed, we need answers to all of the following questions.

1. When did the illness or injury occur? (MM/DD/YY): _____
2. Is this illness due to an MVA: ( ) Yes ( ) No
   a. If yes, do you have an attorney: ( ) Yes ( ) No
   b. _____ Attorney Name
3. Where did the illness or injury occur? _____
4. How did the illness or injury occur? _____
5. Is this illness or injury someone else's fault:( ) Yes ( ) No
   Explain? _____
6. Is your illness/injury work related? ( ) Yes ( ) No
   (If yes, continue to answer questions 7 and 8.)
7. Did you report the condition to your employer? ( ) Yes ( ) No
   If yes, to whom? _____
8. Do you expect to receive or have you been provided with Workers' Compensation Benefits? ( ) Yes ( ) No
   Note: Workers' Compensation is not the same as state disability.

This form will be submitted with your claim to your insurance carrier.
Contact your insurance carrier for any questions.

Signature Patient/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

NOTE: If additional space is needed, please use the back of this form.

SERVING LAS VEGAS FOR OVER 40 YEARS

Corporate Address
3777 Pecos-McLeod, Ste 102
Las Vegas, NV 89121
(P) 702-731-6873 (F) 702-731-2565

www.closept.com

West Side Location
8084 W. Sahara Ave., Ste A
Las Vegas, NV 89117
(P) 702-834-7689 (F) 702-684-5674

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Signature_____ **Please Print**_____

Date _____