Chronic Pain Recovery Center
Aquatic Therapy
111 Vision Park Blvd., suite 100
Shenandoah, TX 77384
Phone (936) 321-0214 Fax (936) 271-0219

Worker's Comp - Patient Profile

Aquatic Therapy

Appt Date: _____ Referring Physician: _____

Appt Time: _____ Primary Physician: _____

Referral on file: ( ) Yes ( ) No

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ SS#: _____

City, St, zip: _____ Sex: ( ) M ( ) F

Home Phone: _____ Employer: _____

Cell Phone: _____ Work Phone: _____

Email address: _____ DOI: _____

Patient Signature: _____ Date: _____

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Patient name:_____ SS#_____
Insurance company:_____

Release of information: I hereby authorize CPRC to release any or all information acquired in the course of my examination and/or treatment that may be required to process claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

Medicare Patients Certification: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT WORKER'S COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

_____ MEDICARE is my Primary coverage. _____ This is NOT a Work Related condition.

_____ MEDICARE is my Secondary coverage. _____ This IS a Work Related condition.

_____ I do not have MEDICARE/HMO.

_____ I do not have MEDICAID/HMO.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to Dr. Samuel Alianell of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

_____ _____
Signature of Insured/Guardian Date Witness Date

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CHRONIC PAIN RECOVERY CENTER (CPRC)

NOTICE OF PRIVACY PRACTICES

PLEASE READ THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. AFTER RECEIVING THIS NOTICE YOU WILL BE ASKED TO CONSENT TO THE USE OF YOUR INFORMATION AS DESCRIBED.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF CPRC'S NOTICE OF PRIVACY PRACTICES.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

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FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in you care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family, Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you?

Phone Number: _____
What is this number (home, work, cell, other)? _____

From time to time we will leave a message for you on an answering machine, voice mail, or with another individual in your absence. Is it okay for such messages to include details (such as diagnosis and medication information) at this number? _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.

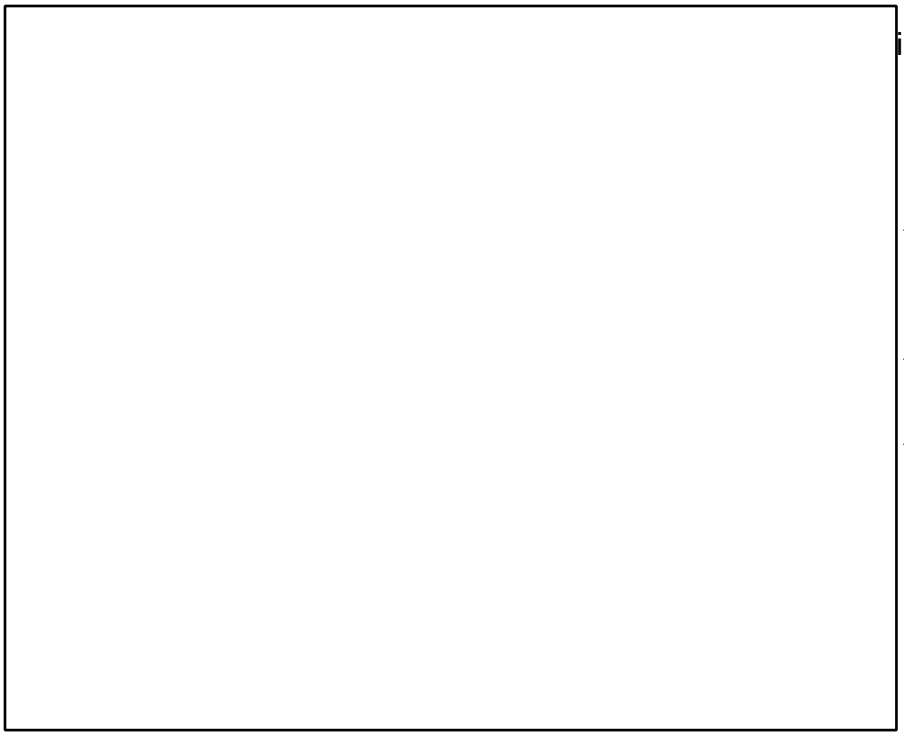
Home phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Work number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Cell Phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Other: _____
Is it okay to leave a detailed message at this number in your absence? _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print name of Patient or Legal Representative Relationship to Patient

Patient Name:_____ Age:_____ Today's Date:_____
Preferred Mode of Contact by therapist:
Phone:_____ E-Mail:_____
Emergency Contact:_____Relation:_____
Best Contact Number:_____

PRESENT SYMPTOMS: Please describe what brings you in for evaluation:
_____
_____
_____



iagram the areas you have symptoms:
Pain Type: (Check any/all that apply):

____Sharp ____Aching ____Burning

____Throbbing ____Deep ____Radiating

____Superficial ____Tingling ____Numb

Pain Severity: (0= None; 10= Severe)

1 2 3 4 5 6 7 8 9 10

Mark you current pain level with and 'X'
Frequency:
_____Constant _____Intermittent
If constant, does the intensity vary?
____Yes ____ No

Do you have any fear of water? ____NO ____YES Do you know how to swim? ___YES ___NO

What influences your pain?
What activities/positions increase your symptoms? (Circle)
Sit Lay Stand Rest Activity Walk Ice Heat Other_____

What activities/position decrease/lessen your symptoms? (Circle)

Sit Lay Stand Rest Activity Walk Ice Heat Other_____

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Please

Activity	No Difficulty	With Difficulty/ Pain	Cannot Perform
Personal Hygiene: Hair, bathing, toilet			
Dressing: Zippers/Buttons, Upper Body, Lower Body, Shoes			
Household Chores: Reaching overhead, lifting/ carrying, dusting, vacuuming, mopping, laundry			
Mobility: Walking, Stairs, Curbs, Incline, Decline, Uneven ground, Distances, sitting			
Meal Prep- using oven, stove, reaching in fridge/ freezer, Eating, Clean Up- doing dishes, dishwasher			
Transportation: Driving, riding as passenger, bus, taxi, shopping			

List your leisure/ fun activities: (Circle those activities affected by your current condition)

_____

_____

_____

How long can you do the following activities before the pain start?

Sitting: _____ Minutes/Hours or Unlimited
Standing: _____ Minutes/Hours or Unlimited
Walking: _____ Minutes/Hours or Unlimited
Driving/Riding in a car: _____ Minutes/Hours or Unlimited
Lifting: _____ Minutes/Hours or Unlimited

Prior Medical History:

_____

_____

Are you currently seeing any other provider for this condition?

_____

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Who is the physician that we can thank for referring you to our services?

_____

What are your goals for coming in for treatment?

_____

_____

Please tell us anything more that you would like your therapist to know:

_____

_____

111 Vision Park Boulevard, Suite 100
Shenandoah, TX 77384-3003
Phone: 936-271-0221 Fax: 936-271-0219

PATIENT INFORMATION

Thank you for choosing Chronic Pain Recovery Center! We welcome you and look forward to a long relationship together. Office hours are Monday through Friday, 8:00AM to 5:00 PM. We are not open on evenings or weekends.

Here are some things that you need to know!

Billing Office Phone numbers

Dale Billing Resources: (281) 419-9669.

Appointment Cancellation

If you are unable to keep your appointment, please call the office 24 hours in advance. If less than 24 hours notice is received, a charge of $50.00 will be incurred. The intent of the fee is to ensure access to the aquatic program for patients who need care. This appointment was set aside for you and when you no show or cancel with less than 24 hours notice, another patient who is in pain cannot receive the care they need. With 24 hours notice, we are often able to fit a patient in who might otherwise have to wait. We will **NOT** be able to schedule you again with out receiving the "No Show" payment.

Check Returns

A fee of $35 will be charged for each check returned for insufficient funds.

Phone Calls

It is the policy of this office that phone calls are returned within 24 hours from the time the message is received, although every effort is made to return call the same day. However, phone messages received after 3:30PM will not be returned until the following business day.

Medical Records

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There is a $25.00 fee for the first 20 pages and $.50 for each additional page to copy your medical records for your personal use. For patient protection and confidentiality reasons, we require the patient to personally sign an Authorization to Release Medical Records when requesting personal copies. These records may be picked up by the patient. There is no charge to you for sending a copy of your medical record to a referring physician.

Acknowledgement that I have read and understand the patient information packet.

I acknowledge that I have read the information on page 1 of this packet.

_____

Print Name

_____

Signature

_____

Date