Lower Extremity Functional Scale

Patient name: Date:

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention.

Please provide an answer for each activity.

Today, do you or would you have any difficulty with:

	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, housework, or school activities.	☐	☐	☐	☐	☐
Your usual hobbies, recreational or sporting activities.	☐	☐	☐	☐	☐
Getting into or out of the bath.	☐	☐	☐	☐	☐
Walking between rooms.	☐	☐	☐	☐	☐
Putting on your shoes or socks.	☐	☐	☐	☐	☐
Squatting.	☐	☐	☐	☐	☐
Lifting an object, like a bag of groceries from the floor.	☐	☐	☐	☐	☐
Performing light activities around your home.	☐	☐	☐	☐	☐
Performing heavy activities around your home.	☐	☐	☐	☐	☐
Getting into or out of a car.	☐	☐	☐	☐	☐
Walking 2 blocks.	☐	☐	☐	☐	☐
Walking a mile	☐	☐	☐	☐	☐
Going up or down 10 stairs (about 1 flight of stairs).	☐	☐	☐	☐	☐
Standing for 1 hour.	☐	☐	☐	☐	☐
Sitting for 1 hour.	☐	☐	☐	☐	☐
Running on even ground.	☐	☐	☐	☐	☐
Running on uneven ground.	☐	☐	☐	☐	☐
Making sharp turns while running fast.	☐	☐	☐	☐	☐
Hopping.	☐	☐	☐	☐	☐
Rolling over in bed.	☐	☐	☐	☐	☐

Total: ____/80

LARSON REHABILITATION
PHYSICAL THERAPY & EMG TESTING

LARSON REHABILITATION
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PATIENT MEDICAL INFORMATION

NAME (Last, First):

_____

GENDER: ☐Male ☐Female

HOW DID YOU HEAR ABOUT US?
☐Referring Dr _____
☐Friend or Family:_____
☐Website ☐Newspaper ☐Radio
☐Other:_____

EDUCATION:
Highest grade completed:
1 2 3 4 5 6 7 8 9 10 11 12 12+
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

EMPLOYMENT/WORK (Job/School/Play)
☐Work full-time ☐Work part-time
Occupation:_____
☐Homemaker ☐Retired ☐Student
☐Unemployed ☐Disabled

GENERAL HEA LTH STATUS
Are you: ☐Right-handed ☐Left-handed

Please rate your health:
☐Excellent ☐Good ☐Fair ☐Poor

Are you using:
☐Cane ☐Walker ☐Wheelchair
☐Glasses, hearing aids ☐Other:_____

SOCIAL/HEALTH HABITS
Do you currently smoke?
☐No ☐Yes- # of packs per day: _____

Do you currently drink alcohol?
☐No ☐Yes- # of drinks on average_____

Do you exercise beyond normal daily activities and chores?
☐No ☐Yes_____

CURRENT CONDITIONS/CHIEF COMPLAINTS
Reason for your visit : _____
When did the problem start (date):_____

Are you seeing anyone else for this problem?
☐No ☐Yes, what specialty:_____

MEDICAL/SURGICAL HISTORY

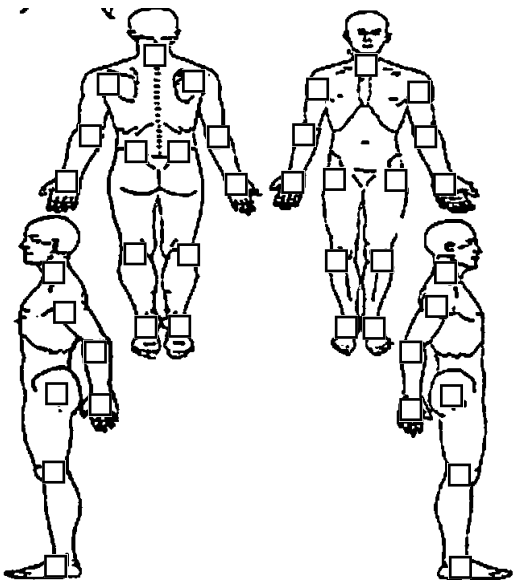
Please check if you have ever had:

☐Arthritis	☐Blood disorders
☐Repeated infections	☐Circulation/vascular problems
☐Concussion	☐Depression
☐Heart problems	☐High blood pressure
☐Kidney problems	☐Lung problems
☐Skin disease	☐Stroke/CVA/TIA
☐Thyroid problems	☐Ulcers/stomach problems
☐Multiple sclerosis	☐Developmental problems
☐Muscular Dystrophy	☐Osteopenia/Osteoporosis

☐Diabetes/high blood sugar
☐Hypoglycemia/low blood sugar
☐Broken bones: _____
☐Cancer Type:_____
☐Seizures/epilepsy(last event)_____
☐Allergies, Type_____
☐Infectious disease (e.g.,TB, hepatitis)

Have you ever had surgery?
☐No ☐Yes, please describe including dates:
_____
_____
_____
_____

Are you taking any medications?
☐No ☐ Yes, please list including proper dosage and frequency:
_____
_____
_____



Please check area of pain

LARSON REHABILITATION
PHYSICAL THERAPY & EMG TESTING

BILLING, PRIVACY, & INFORMED CONSENT

Appointment Cancellations
As a courtesy to our office and other patients, please notify our office as soon as possible if you need cancel or reschedule an appointment. If repeated absences occur, it may be necessary to assess a $50.00 fee for the negative impact on patient care. This charge is not billable to an insurance company and will be your responsibility.

Diagnostic Procedures
For those patients receiving diagnostic treatment, please know that we will check on any prior authorizations required for your procedure. This authorization is not a guarantee of benefits; it is merely a statement by your insurance company that they agree with the course of treatment. You should still call your insurance yourself and notify them of your proposed treatment plan.

Billing Policy, Release, and Authority for Assignment of Benefits
I authorize Larson Rehabilitation Services, PLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Larson Rehabilitation Services. PLC.

I authorize Larson Rehabilitation Services, PLC to release or obtain medical or other information necessary to process the claims for services rendered during treatment. I understand that some insurance companies require medical or administrative pre-authorization for treatment, in-network providers, or have reimbursement limits on my rehabilitation treatments. I understand that I am ultimately responsible for knowing and meeting the requirements of my particular insurance plan. I understand that most insurance companies have a co-pay and a deductible that must be met before the insurance company will pay their portion, and I understand that I am responsible for any charges (deductibles, co-pays, etc.) until my responsibility is met. Co-pays and deductibles are due at the time of service. It is our policy for Physical Therapy appointments to collect $65.00 per visit until your deductible is met or we determine the actual allowable amount identified by your insurance policy. *In the event that my insurance company determines that the PT treatment or EMG/NCV is medically unnecessary, despite the recommendation of my healthcare providers, I understand that I elect to have these services and will be responsible for those charges not covered by my insurance policy.*

Collection Policy
I understand that unpaid balances consisting of co-payment, co-insurance, deductible amounts and any other amounts not covered by my insurance company are my responsibility and must be paid in full, or payment arranged within 30 days of the statement date. Unless payment arrangements have been approved by the office manager, all final account balances 60 days and older will be referred to a collection agency. The administrative fees associated with the collection process will be added to the patient balance. Payment plans are available with approval from the billing manager. Payment arrangements may only be extended for 90 days following the date of the first statement. Payment arrangements must have a credit/debit card on file and charges will be applied automatically on the first business day of each month.

I understand that there will be a $35.00 charge for returned checks. In addition, if I am involved in litigation or payment dispute for personal injury which may delay payment, interest of 10% will be applied annually to the outstanding balance beginning 30 days after the start of treatment. If the claim is being submitted to a worker's compensation plan and is subsequently denied, I authorize Larson Rehabilitation to submit my claim to my current medical insurance carrier. I understand that Larson Rehabilitation Services will refund any deductible over-payments of more than $15.00 within 30 days of insurance payment.

Privacy Policies
I certify that I have received a copy of the Privacy Practices for Larson Rehabilitation Services, PLC.

Informed Consent
I have the right to understand the rehabilitation plan. The purpose of each treatment device including risks and benefits will be explained to me. I also have the right to decline treatment at any time.

I HAVE READ AND UNDERSTAND THE INFORMATION OUTLINED ABOVE.

Signature: _____Date:_____

EMG/NCS TESTING INFORMED CONSENT

Nerve Conduction Studies (NCS)
This portion of the study uses electricity to stimulate the nerves at various parts of the body. The current is low and usually only causes a slight tingle or muscle twitch.

Electromyography (EMG)
This portion of the study uses pin type electrodes that are placed in the muscle to sec how well the muscles and the nerves are communicating. We use disposable electrodes and use safety precautions to maintain a sanitary environment. This portion of the test may cause a cramp or ache like sensation. Occasionally you may experience some slight bruising; however, this will resolve normally and usually requires no further medical attention.

You have been referred for this testing because your healthcare provider has felt that it will aid in the management of your health. The information obtained from this testing will be sent to your referring physician or other healthcare provider from whom you have sought medical attention.

You have the right to withdraw at any time from the testing. After the testing is complete, it is anticipated that no residual effects will be felt other than those described above. Testing will not prevent you from eating or driving.

I ACKNOWLEDGE THAT THE ABOVE INFORMATION HAS BEEN PROVIDED AND CONSENT TO THE TESTING.

Signature:_____ Parent/Guardian signature: _____Date:_____

LARSON REHABILITATION
PHYSICAL THERAPY & EMG TESTING

NOTICE OF PRIVACY PRACTICES

OUR PLEDGE

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at Larson Rehabilitation Services. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you, we also describe your rights and certain duties we have regarding the use and disclosure of the medical information.

OUR LEGAL DUTIES

Law requires us to:

A. Keep your medical records private.
B. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
C. Follow the terms of the items in this notice.

We have the right to:

A. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by the law.
B. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep; including information previously created or received before the changes.

Notice of the changes to privacy practices:

A. Before we make an important change in our privacy practices we will change this notice and make the new notice available upon request.

USE & DISCLOSURE OF YOUR MEDICAL INFORMATION

This is how we use and disclose medical information. Note: We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you may provide may be revoked at any time by writing to us.

For treatment:

We may use medical information about you to provide you with physical therapy treatment or EMG services. We may disclose medical information about you to doctors, nurses, technicians, physical therapy students, or other people who are involved in your care. We may also share medical information about you with other health care providers to assist them in treating you.

For payment:

We may use and disclose your medical information for payment purposes.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating employees. conducting training programs, and getting the accreditation certificates, licenses, and credentials we need to serve you.

Additional Uses and Disclosures:

In addition, we may use the Information for:

A. Research in limited circumstances. Physical therapy information for research purposes when no anonymity is maintained.
B. Court orders, judicial and administrative proceedings. We may disclose your medical information to a court or administrative order, subpoena or other lawful process.
C. Victims of abuse, neglect or domestic violence. We will disclose information to appropriate authorities if we reasonable believe that you may be a victim of abuse, neglect, or domestic violence.
D. Law enforcement. under certain circumstances we may disclose health information to law enforcement officials.
E. Military activity, inmates, work compensation and disclosure to the Secretary of the US Department of Health and Human Services.

YOUR INDIVIDUAL RIGHT

You have the right to:

A. Look at or obtain copies of your medical information. You must make your request in writing. There may be a fee for copying and for postage if you would like the copies mailed to you. Ask the receptionist for fee information.
B. Receive a list of all the times we shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
C. Request that additional restrictions be placed on our use or disclosure of your medical information. At times we may not be able to agree to the request; however, if we do, we will abide by our agreement (except for an emergency).
D. Request that we change your medical information. We may deny the request If we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you with a written explanation.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, please ask the receptionist or physical therapist for help. If you have concerns about your privacy rights contact the person named above. You may also submit a written complaint to the US Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

1600 W University Ave #106, Flagstaff, AZ 86001
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