OrthoCare Physical Therapy and Sports Rehabilitation

PATIENT REGISTRATION FORM

Last Name: ___________________________ First Name: _______________________ Male ❑ Female ❑

Date of Birth: ______________________Age: ________________________

Marital Status: Married ❑ Divorced ❑ Single ❑ Widow ❑ Other ❑

MAILING ADDRESS

Street Address: ___________________________ City: _____________ State: ________ Zip: ________________

E-mail Address: ____

CONTACT INFORMATION

Home Phone #: ____________________ Work #: ___________________ Cell #: ___________________________

Responsible Parent or Guardian if Patient is under 18: ____

Emergency Contact: ___________________ Phone #: ______________ Relation to patient: _________________

Referring Physician: ___________________________________ Phone #: _________________________________

Primary Insurance Information

****All information pertains to the policyholder****

Insurance Name: ________________________________ ID #: ____

Policy Holder: ____________________________________ Relationship to patient: ___________________________

Address: (if different from patient) ____

Date of Birth: _____________________________

Secondary Insurance Information

****All information pertains to the policyholder****

Insurance Name: ________________________________ ID #: ____

Policy Holder: ____________________________________ Relationship to patient: ____________________________

Address: (if different from patient) ____

Date of Birth: _____________________

Worker's Compensation or No-Fault Insurance only

Insurance Company Name/: ____

Address: ________________________ City: ____________________ State: _______ Zip________________________

Contact Name______________________________ Phone____________________ Fax: __________________________

WCB: _____________________ Carrier Case#: _______________________ Claim/File#: _______________________

Date of Accident: ________________ Policy Holder: ____

I hereby authorize the release of any medical information necessary to process my insurance claim and request direct payment be made to OrthoCare Physical Therapy and Sports Rehabilitation, PC. I authorize the physical therapists to proceed with my care of such rehabilitation procedures permitted by the NYS statues and under the appropriate scope of practice, in the judgment of the physical therapist deemed necessary. I understand I will be responsible for ALL charges not covered by my insurance including co-payments, co insurances and deductibles. Any such payment will be required at the time of services rendered. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions and if said referrals are not obtained, I am responsible for charges not covered under the referral.

Patient (Parent/Guardian) Signature: ____ Date: ___________

OrthoCare Physical Therapy
And
Sports Rehabilitation, P.C.

1053 Saw Mill River Road, Suite 105
Phone: (914) 693-2350 Ardsley, NY 10502 Fax: (914) 693-7661

NOTICE OF PRIVACY PRACTICES

The purpose of this notice is to describe how your medical information is used, to whom it is disclosed and how you gain access to it. Orthocare Physical Therapy and Sports Rehabilitation, P.C. and Benito Giampaglia, PT as a medical provider is permitted by law to collect, use and disclose your "protected health information" or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information. Orthocare Physical Therapy and Sports Rehabilitation, P.C. agrees to abide by terms of this notice but reserves to right to change the terms at any time. Should we do so, we will notify you in writing.

I. Use and Disclosure of Protected Health Information:

When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we serve. Your physician, office staff and others outside of OrthoCare Physical Therapy and Sports Rehabilitation, P.C., i.e. your insurer are allowed to access this information. Some examples of uses and disclosures of your protected health information are for:

- treatment by your doctor
- coroners, funeral directors
- reporting public health risks
- payment for your treatment by you or your insurance
- reporting adverse events of medications or medical devices to FDA
- OrthoCare Physical Therapy and Sports Rehabilitation, P.C. to determine if we meet the needs of your patients.
- appointment reminders
- law enforcement
- worker's compensation
- organ or tissue donation

II. Your Rights Regarding Your Protected Health Information:

A. You have the right to **inspect at our office at a mutually agreeable time, and to obtain a copy** of your protected health information for a long as this office maintains your record. We are permitted by NYS law to charge you a fee of $.75 per page.

B. You have the right **to restrict or to limit the use of your** protected health information that we use for treatment, payment or operations. You can restrict the release of your health information to family or friends unless they have your written or verbal permission. OrthoCare Physical Therapy and Sports Rehabilitation, P.C. reserves to right to deny you treatment should you restrict the use of your protected health information for treatment, payment or operations.

C. You have the right to request **an accounting of disclosures made of your health information**. Your request must be submitted in writing, specifying dates and time periods as far back as 6 years from today, as long as the events in question happened after April 14, 2003.

D. You have the right **to amend your protected health information**. Your request must be given in writing along with a reason for doing so. Your request can be denied (a) if the information originated outside OrthoCare Physical Therapy and Sports Rehabilitation, P.C.; (b) if it is outside the information you are entitled to inspect or copy; (c) if the information in the record is correct.

E. You have the right **to request confidential communications** as long as it is done in writing. For example, you can specify that we only contact you at work, at home or by mail, etc.

If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to Benito Giampaglia or you may contact the Secretary of the Department of Health and Human Services for the USA.

I, the undersigned, acknowledge that I have received a copy of OrthoCare Physical Therapy and Sports Rehabilitation, P.C. notice of privacy practices. Should I have any questions about the policy, I will discuss with the office.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Print Name Date

I make the following request for confidential communication of my medical information:______________________

____

____
Signature Date

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________ ***Date*** ______________

1. *Describe your symptoms* ______________________

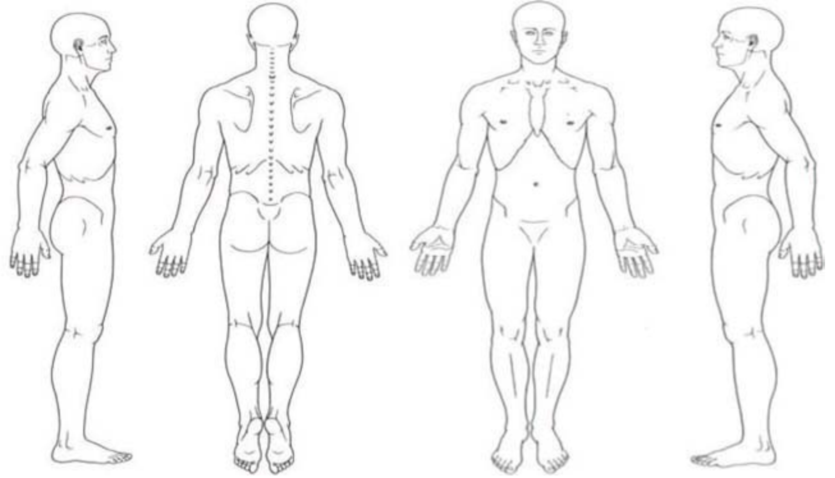
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. *How often do you experience your symptoms?*

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. *What describes the nature of your symptoms?*

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. *How are your symptoms changing?*

① Getting Better
② Not Changing
③ Getting Worse

5. *During the past 4 weeks:*

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *During the past 4 weeks how much of the time has your condition interfered with your social activities?* *(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. *In general would you say your overall health right now is...*

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. *Who have you seen for your symptoms?*

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* ________ ③ CT Scan *date:* ________
② MRI *date:* ________ ④ Other *date:* ________

9. *Have you had similar symptoms in the past?*

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. *What is your occupation?*

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ ***Date*** ______________

MEDICARE

Name: ____ Date: ____________________

PLEASE RATE YOUR PAIN OVER THE LAST 3-4 DAYS:

PAIN LOCATION: ____

0= None 5= Moderate 10= Unbearable

Worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

Best: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain ____ (i.e. Throbbing, stabbing, burning, tingling etc.)

Body mass index: (verbal):

Height: ______________

Weight: ______________

For office use only: (measured)

____

____

Please list all current medications with dosage/ frequency. Route (i.e. oral, injection, etc.)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

<u>OrthoCare Physical Therapy</u>

<u>Financial Policy and Patient Guidelines</u>

1. I understand that my co-pay, co-insurance and/or deductible are due at the time of my visit.
2. I understand that I am responsible for all charges NOT covered by my insurance.
3. I understand if I have an unpaid balance to OrthoCare Physical Therapy and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.
4. In order for OrthoCare Physical Therapy or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that OrthoCare Physical Therapy and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.
5. If a check on my account is returned from the bank, I will incur a $25.00 service charge.
6. I understand OrthoCare may place a 21% interest rate on all unpaid balances past 90 days.
7. In order to achieve maximum benefit from your rehabilitation program, it is imperative that you attend your physical therapy appointments and follow your home instruction program **(COMPLIANCE TO YOUR PHYSICAL THERAPY IS THE KEY TO <u>YOUR</u> RECOVERY).**
8. I understand I will incur a $25.00 service charge for any appointments that are missed without a 24-hour notification to the office. This amount will be due at your next visit in addition to your regular co-pay or co-insurance amount. (*It would be fraudulent to submit this fee to your insurance carrier).*
9. I understand it is my responsibility to schedule appointments at least one to two weeks in advance.
10. OrthoCare Physical Therapy reserves the right to reschedule an appointment if I am 15 or more minutes late.
11. If three or more consecutive appointments are missed any time during my treatment, all remaining scheduled appointments may be removed. I will be asked to call and check availability for the day I plan to attend.

Your cooperation is greatly appreciated. We look forward to working with you to obtain optimal outcomes from your rehabilitation program.

I hereby verify that I have read and understand the stated financial policies and patient guidelines for the office of OrthoCare Physical Therapy and Sports Rehabilitation, PC.

Signature: ____

Patient Name: ____ **Date:** ______________________

By refusing to sign the above document, OrthoCare Physical Therapy and Sports Rehabilitation, PC has the right to refuse to treat the patient unless it is an emergency.

Reason Patient Refused to Sign: ____

Witness: ____ Date: _______________________