Connecticut Physical Therapy Specialists

GET BETTER. STAY BETTER.

Personal Information

(Please Print, Preferably Black Ink)

Name:_________________________________ Date of Birth:_____________Today's Date:____________

Address:____ City:______________________

State:_____ ZIP:__________ Cell Phone:_____________________ Home Phone:_____________________

Work Phone:________________ Email:____

Occupation:_________________________Employer Name:_______________________________

Emergency Contact Name:____

Phone Number:___________________________ Relationship: _______________________

Auto Accident Related? YES [ ] NO [ ] Work Related Injury? YES [ ] NO [ ] "Other" Injury? YES [ ] NO [ ]

If you answered **"YES"** to either question above: Date of injury: ________________State injury occurred:_____

Referring Physician:________________________ Referring Physician Group:_________________________

City:_________________State:___________ Phone#:________________________________

Primary Physician:__________________________ Primary Physician Group:_________________________

City:_________________State:___________ Phone#:________________________________

Please Be Aware

- **Medicare Information:** Medicare requires that an actual doctor's visit must occur every 90 days to continue physical therapy coverage. You may need to sign an **Advance Beneficiary Notice (ABN)**.
- **Insurance Information:** The Insurance Company may require Pre-Authorization. Please check with your individual insurance company. What is your Deductible:$_____________Co-pay:$_____________ Co-Insurance:$_____________

(By signing below:)

- I understand if I do not show up for an appointment I **WILL** be charged for that visit.
- I understand if I cancel an appointment with less than 24 hours notice I **MAY** be charged for that visit.
- I understand being late by **MORE** than 10 minutes may require me to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellation are unpredictable.
- I understand children requiring supervision are **NOT** allowed to attend sessions. If the child does not require supervision and is capable of waiting quietly then they can be brought and sit in the waiting area.
- I understand I must inform CTPTS of **ANY** change in insurance plan.
- I understand to limit my cellphone use to emergencies **ONLY**

Patient Signature:____ **Date:**_______________

(Signed by Parent or Guardian if under age 18 or dependent)

Assignment of My Benefits

IMPORTANT: All information must be completed or we will NOT be able to do the courtesy of dealing directly with your insurance.

Benefit Info

Primary Insurance Information

Insurance Company:______________________________ Subscriber Identification Number:_____________________________

Subscriber Group ID: Number______________________________

IF PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY GIVE THEIR INFO HERE: (otherwise, skip this portion)

Policyholder Name:____ Date of Birth:______________ SSN:_________________

Address (if different than Patient):_______________________________________ City:__________ State:______ ZIP:________

Relationship to Patient: __ Spouse __ Parent __ Child __ Other: ___________________________

Secondary Insurance Information

Insurance Company:___________________________ Subscriber Identification Number:_________________________

Subscriber Group ID: Number___________________________

Workman's Comp/Auto Accident Information

Company Handling Claim:_________________________________ Claim#:______________________________

Adjuster Name:__________________________ Phone#:____________________ Ext:__________ Fax#:_______________________

Attorney Information

Attorney Group:_______________________________ Attorney Name:_______________________________

Phone#:_____________________________ Fax#:___________________________ Auto - MedPay on Policy?:$________________

Address:____ City:________________________ State:______ ZIP:___________

I hereby instruct and direct _______________________ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

Connecticut Physical Therapy Specialists
9 Mill Pond Road
Granby, CT 06035

Connecticut Physical Therapy Specialists
620 Norwich-New London Turnpike (Route 32)
Uncasville, CT 06382

Connecticut Physical Therapy Specialists
1240 Park Street, Pope Park Commons, P1E
Hartford, CT 06106

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

☐ A photocopy of this Assignment shall be considered as effective and valid as the original.

☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

☐ I authorize the use of this signature on all insurance submissions.

☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.

☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this ______ day of ______________, 20______.

_______________________________ Signature of Policyholder

_______________________________ Witness

_______________________________ Signature of Claimant, if other than Policyholder

Patient Name:______________________________ Insurance Company:______________________________

Date:__________ Date of Birth/Age:____________________ Patient ID #:______________________________

ICD-10 Code(s):______________________________ Diagnosis:______________________________

Referring Physician:______________________________ Next follow-up Date:______________________________

Are you latex sensitive? ☐ Yes ☐ No Do You Smoke? ☐ Yes ☐ No Do You have a pacemaker? ☐ Yes ☐ No

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FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐Yes ☐ No

ALLERGIES: List any medication(s) you are allergic to: ______________________________

Have you RECENTLY noted any of the following (check all that apply)?

☐ fatigue ☐ numbness or tingling ☐ fever/chills/sweats ☐ muscle weakness ☐ nausea/vomiting ☐ fainting ☐ falls

☐ dizziness/lightheadedness ☐ shortness of breath ☐ weight loss/gain ☐ balance problem ☐ difficulty swallowing

☐ cough ☐ changes ☐ in bowel or bladder function ☐ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer ☐ depression ☐ thyroid problems ☐ heart problems ☐ lung problems ☐ diabetes ☐ chest pain/angina

☐ tuberculosis ☐ osteoporosis ☐ high blood pressure ☐ asthma ☐ multiple sclerosis ☐ circulation problems

☐ rheumatoid arthritis ☐ epilepsy ☐ blood clots ☐ other arthritic condition ☐ stroke ☐ anemia ☐ hepatitis

☐ kidney problem/infection ☐ liver problems ☐ bone or joint infection ☐ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ cancer ☐ diabetes ☐ tuberculosis ☐ heart problems ☐ stroke ☐ thyroid problems

☐ high blood pressure ☐ depression ☐ blood clot(s)

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

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How & what date (roughly) did your problem (injury) start?: ______________________________

____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

____

____

Do you have a history of falls?: ☐ Yes ☐ No; If yes please explain:______________________________

____

Easing Factors: Identify up to 2 important positions or activities that make your symptoms better:

1. ______________________________ 2. ______________________________

Aggravating Factors: Identify up to 2 important activities that you are unable to do or are having difficulty with as a result of your problem.

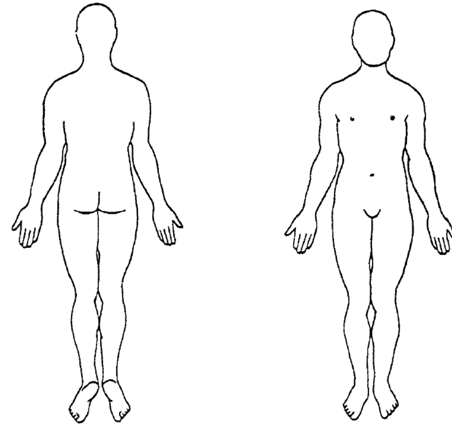
1. ______________________________ 2. ______________________________

When are your symptoms worst?: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

When are your symptoms the best?: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After activity

Therapist Name:	**Therapist Initials:**

Body Chart:



Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same
☐ Come and go ☐ Are Constant ☐ Are constant, but change with activity

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Circle your **current** level of pain while completing this survey: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **best** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

Circle the **worst** your pain has been during the past 24 hours: …0…1…2…3…4…5…6…7…8…9…10…

BELOW FOR OFFICE USE ONLY

OBJECTIVE FINDINGS Discipline: PT / OT Involved Region: Left / Right / N/A

Strength (0-5) Muscle	Grade	**Range of Motion** Motion	PROM	AROM

✷ = **Pain**

Functional Deficits / Additional Information: **Work Related?** ☐ Yes ☐ No

Specific Treatment Plan:

Treatment Goals:

Projected Frequency / Duration of Treatment:

Therapist Signature: **Printed Therapist Name and License #:**

CT
PTS
Connecticut Physical Therapy Specialists
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Current Medication List

For use if medication log is not otherwise provided. Please complete the following information about **ALL** current medications and give to the Health Care Practitioner.

Drug Name	Dosage	Frequency	Prescribing MD	ROUTE: (By Mouth) = P.O. (Injection) = INJ. (Skin/Topical) = S

Connecticut Physical Therapy Specialists
Statement of Privacy Notice

Effective March 1, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this offices at **(860) 413-9969 (Granby) or (860) 237-3510 (Uncasville) or (860) 461-7940 (Hartford)**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this offices at **(860) 413-9969 (Granby) or (860) 237-3510 (Uncasville) or (860) 461-7940 (Hartford)**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____

Print: Patient Name

____

Patient's Signature **Date**

____

Authorized Facility Signature **Date**