



Registration Form

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS#: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Marital Status: married single widowed Gender: male female

Referring Physician/Phone# _____ Date of Prescription: _____

Duration: _____ Body Part: _____ Referral #: _____

Onset Date/Date of Injury: _____

Employer Name: _____ Phone#: _____

Emergency Contact: _____ relationship _____ Phone#: _____

Insurance Information

Primary Insurance:

Insurance Co.: _____ Plan: _____

Policy/ID or Claim #: _____ Group: _____

Insurance Phone #: _____ Rehab. Nurse/Adjuster: _____

Adjuster Phone #: _____ Adjuster Fax #: _____

Who did you speak with? _____ Eff. Date: _____ Copay \$ _____

Referral needed? Yes No Deductible? _____ Co-Insurance? _____

Any other terms(i.e. max visits, cap for re-imburement?): _____

Mailing address to submit claims: _____

Have you had any prior therapy this year? (PT/OT or Chiro) Yes No

Secondary Insurance:

Insurance Co.: _____ Plan: _____

Policy/ID or Claim #: _____ Group: _____

Insurance Phone #: _____ Address: _____

Only ask the following if the insurance carrier is not the patient (Ins. ID # is not the same as pt's SS#)

Last Name: _____ First Name: _____ MI: _____

Employer Name: _____ Phone Number: _____



PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Date of injury / onset: ____ / ____ / ____

Are you presently working? Yes / No

Check which apply to your symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> work related injury | <input type="checkbox"/> injury related to falling | <input type="checkbox"/> recurrence of previous injury |
| <input type="checkbox"/> athletic / recreational injury | <input type="checkbox"/> injury related to lifting | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> cause unknown | <input type="checkbox"/> motor vehicle accident | |

Have you had surgery relating to your injury? Yes No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Ringling in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please briefly explain and provide approximate date(s):

Are you presently taking Medication(s)? Yes No

If yes, please list medications and for what condition:

Please rate your pain from 0 to 10 presently (0 is no pain, and 10 is the worst imaginable pain) _____

Patient's Signature _____	Date _____	Signature of Guardian if patient is a minor _____	Date _____
---------------------------	------------	---	------------

PhysioCare Rehabilitation, L.L.C.
Notice of Privacy Practices

Acknowledgment of Receipt of Notice

Patient name: _____ Medical Record Number _____

I have received a copy of PhysioCare Rehabilitation's Notice of Privacy Practices.

Signature: _____ Date _____

If personal/legal representative: Name: _____

Relationship to Patient: _____

Reason signature not obtained:

Patient too sick to sign at this time.

Patient would not sign.

Other: _____

Name of PhysioCare Rehabilitation employee attempting unsuccessfully to obtain signature:

Date: _____

Notes: (1) Except in an emergency treatment situation the rehabilitation company must make a good faith effort to obtain the signature of the patient or personal representative acknowledging receipt of the Notice.

(2) If the signature cannot be obtained, the company must document its efforts to obtain the signature and the reason why the signature was not obtained.

Notice of Privacy Practices effective April 14, 2003.

::ODMA\PCDOCS\GHCDOCS\347600\1

**PhysioCare Rehabilitation, L.L.C.
Statement of Financial Responsibility**

Patient Name: _____ Account Number: _____

PhysioCare Rehabilitation, L.L.C. appreciates the confidence and trust you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to PhysioCare Rehabilitation, L.L.C. for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to PhysioCare Rehabilitation, L.L.C. I agree to pay PhysioCare Rehabilitation, L.L.C. the full and entire amount of all bills incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

PATIENT SIGNATURE: _____ DATE: _____
GUARANTOR SIGNATURE: _____ DATE: _____
(If guarantor is not the patient.)

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize PhysioCare Rehabilitation, L.L.C. through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to Physical Therapy and/or rehabilitative services.

I further authorize PhysioCare Rehabilitation, L.L.C. to release to appropriate agencies, any information acquired in the course of my or the above named patient's evaluation and treatment.

PATIENT SIGNATURE: _____ DATE: _____
(or parent if patient is a minor)

NO SHOW POLICY

Your therapist designates specific time for your appointment to meet the needs of your rehabilitation program. We understand that there may be times when you must miss an appointment, but we request that you give us 24-hour notice. Please schedule a make-up appointment as soon as possible to help meet your rehabilitation goals.

If you do not come for your scheduled appointment, you will be charged a \$10.00 fee. Your insurance carrier does not cover this fee, therefore, you are personally responsible.

PATIENT SIGNATURE: _____ DATE: _____
(or parent if patient is a minor)

PhysioCare Rehabilitation, L.L.C.
Notice of Privacy Practices

**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.**

PhysioCare Rehabilitation, L.L.C. is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with federal regulations.

By “your health information” we mean the information that we maintain that specifically identifies you and your health status.

Summary

This Notice describes how we use your health information within SIMA, Inc. and disclose it outside SIMA and why.

The Notice covers:

- Uses or disclosures which do not require your written authorization.
 - >> Treatment, payment, and health care operations.
 - >> Uses or disclosures of your health information to which you may object.
 - >> Uses or disclosures required or permitted.
- Uses or disclosures which require your written authorization.
- Your rights as a patient regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgement.

Uses or disclosures which do not require your written authorization

The following categories describe different ways we may use and disclose your health information. For each category we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

Treatment, Payment, and Health Care Operations

We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

PhysioCare Rehabilitation, L.L.C.

Notice of Privacy Practices

Treatment, Payment, and Health Care Operations (continued)

- For treatment, we use your health information to assist in the evaluation, examination, and treatment of your diagnosis. In your record we write the rehabilitative treatment provided to you, your response to treatment, your plan of care, the procedures used and other actions our health care providers take and their observations. We disclose your health information for treatment purposes to healthcare professionals and other people in our company and to physicians, other health care professionals and other individuals outside our company who are involved in your care.
- For payment, we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid to obtain prior approval for treatment or to obtain payment for treatment. We disclose that part of your health information that these organizations require to pay us, including for example, information that identifies you, as well as your diagnosis, procedures, and supplies used.
- For health care operations, we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of serving patients, and to evaluate staff performance.

Uses or Disclosures of Your Health Information to Which You May Object

We may use or disclose your health information for the following purposes, unless you ask us not to.

- Informing family and friends. We may disclose your health information to family, friends, or others identified by you who are involved in your care. We may also give information to someone who helps pay for your care.
- Assistance in disaster relief efforts so disaster relief agencies may be notified of your location, status and condition in the event of a disaster.
- Confirming our visits to your home or other appointments.
- Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you.

If you object to our use of your health information for any of these purposes please contact:
856-435-2323

PhysioCare Rehabilitation, L.L.C.

Notice of Privacy Practices

Uses or Disclosures Required or Permitted

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

- Federal government investigation, when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulations.
- Federal, state or local law requirements.
- Public health activities, for example to report communicable diseases or death; for public health investigations; or for matters involving the Food and Drug Administration such as adverse drug reactions.
- Reporting of abuse, neglect or domestic violence.
- Health oversight activities by a health oversight agency such as inspections, audits, or investigations. (A health oversight agency is an organization authorized by the government to oversee eligibility and compliance and to enforce civil rights laws.)
- Judicial or administrative proceedings, for example responding to a court order or subpoena.
- Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime on our premises.
- Use by coroners, medical examiners, or funeral directors.
- Facilitating organ, eye, or tissue donation.
- Research, provided that very strict controls are enforced.
- Averting a serious threat to your health or safety or that of the public.
- Specialized government functions such as military or veterans' affairs; national security, and intelligence activities.
- To comply with workers' compensation or similar programs which provide benefits for work-related injury or illness.
- Business associates who perform services for our company such as a copy service used to copy medical records, a billing company used to assist us in billing, accountants, lawyers, and similar consultants. Business associates must agree to protect the confidentiality of your health information.

PhysioCare Rehabilitation, L.L.C.
Notice of Privacy Practices

Uses or disclosures which require your written authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than those stated above. If you revoke your authorization, we cannot take back any disclosures we have already made with your permission.

Your Rights As A Patient to Privacy Of Your Health Information

You have the following rights regarding your health information:

- **Right to Request Restrictions**
You have the right to request restrictions on our uses and disclosures of your health information, however we may refuse to accept the restriction.
- **Right to Request Confidential Communications**
You have the right to request that we communicate with you confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. **Your request must be in writing.** We will make every attempt to honor your request.
- **Right to Request Access to Your Health Information**
You have the right to request access to your health information in order to inspect or copy it. **Your request must be in writing.** We may deny your request and, if so, you may request a review of the denial. However, we will make every attempt to honor your request.
- **Right to Request an Amendment of Your Health Information**
You have the right to request an amendment to your health information if you believe the information is incorrect or incomplete.
Your request must be in writing and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.
- **Right to Request an Accounting of Disclosures of Your Health Information**
You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations and other than disclosures to you and certain other exceptions defined by law. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures before April 14, 2003 or for more than 6 years prior to the date of your request.
- **Right to Obtain a Paper Copy of this Notice**
You may request a copy of this notice at any time. If you received this Notice electronically, you have the right to receive a paper copy.

To exercise any of these rights please write PhysioCare Rehabilitation, L.L.C., 205 White Horse Rd., Voorhees, NJ 08043.

PhysioCare Rehabilitation, L.L.C.
Notice of Privacy Practices

Our Duties in Protecting Your Health Information

- We are required by law to maintain the privacy of your health information.
- We must inform patients or their legal representatives of our legal duties and privacy practices with respect to health information. This Notice discharges that duty.
- We must abide by the terms of our Notice of Privacy Practices currently in effect.
- We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain including information we already have and information we receive in the future. At any time, you may obtain a copy of the current notice from our office.

Complaints, Contact Person, Effective Date, and Acknowledgement

- You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated.
- You will not be retaliated against for filing a complaint.

You may file your complaint with our infusion company by writing to: Privacy Officer, PhysioCare Rehabilitation, L.L.C., 205 White Horse Rd., Voorhees NJ 08043.

- You may file a complaint with the Secretary of Health and Human Services by writing to:

Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(*source: www.hhs.gov*)

- For further information you may write to Privacy Officer, PhysioCare Rehabilitation, L.L.C., 205 White Horse Rd., Voorhees NJ 08043.
 - This notice is effective April 14, 2003.
-