



Hands-On Care Physical Therapy P.C

PhysioCare Physical Therapy P.C

EXPLANATION OF PROCEDURES

Welcome to our practice. You are here because you have been referred to us by your doctor for Physical Therapy. Physical Therapy is defined as: "The evaluation, treatment or prevention of disability, injury, disease or other condition of health using physical, chemical and mechanical means including, but not limited to heat, cold light, air water, sound electricity, massage, mobilization and therapeutic exercise..."

Here is the explanation of some of the Physical Therapy procedures and modalities that you may receive during your course of treatment with us. Please make sure that if you have any question you ask your Physical Therapist to answer them to your satisfaction.

PHYSICAL THERAPY EVALUATION (97001): This includes taking a comprehensive history, systems review and tests and measurements. The PT will formulate an assessment, prognosis and note anticipated intervention.

PHYSICAL THERAPY RE-EVALUATION (97002): The PT reexamines the patient and updates goals and treatment plan.

THERAPEUTIC EXERCISE (97110): Therapeutic exercises to develop strength and endurance, range of motion and flexibility.

NEUROMUSCULAR RE-EDUCATION (97112): Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception.

AQUATIC THERAPY (97113): Aquatic therapy with therapeutic exercises.

MANUAL THERAPY (97140): Manual therapy techniques may include mobilization, manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization.

THERAPEUTIC ACTIVITIES (97530): Use of dynamic activities to improve functional performance (activities such as bending, lifting, carrying, reaching etc and have as a goal to improve your functional performance in a progressive manner).

ELECTRICAL STIMULATION (97014 & ULTRASOUND (97035): These are physical agents, used in conjunction with the other treatments to reduce pain, inflammation etc.

GAIT TRAINING (97116): Gait training activities including stair climbing.

SELF CARE, HOME MANAGEMENT TRAINING/ADL TRAINING, SAFETY PROCEDURES ECT: (97535)

GROUP THERAPEUTIC PROCEDURE (97150): Land or aquatic group based activities.

MASSAGE (97124): Effleurage, petrissage and or/ tapotement (stroking, compression etc)

BY SIGNING THIS DOCUMENT I ACKNOWLEDGE THAT I UNDERSTAND THAT I MAY RECEIVE A NUMBER OF THE ABOVE LISTED SERVICES AND ALL OF MY QUESTIONS WERE ANSWERED BY THE TREATING THERAPIST TO MY SATISFACTION.

Patient's Name

Signature

Date

1. American Physical Therapy Association. Guide to physical Therapy Practice. Alexandria, VA: APTA; 1999
2. HCFA Medicare. Physical Medicine & Rehabilitation. Policy Number (YPF#86) (YMED#09) MNB Medicare; 2002
3. NY PT Board, Practice Act. Education Law Article 136: PTs and PTAs 2000. 2000 Directory NYPTA; 2000



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Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

GENERAL OFFICE POLICIES

- 1) We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in **to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.**
- 2) There is a **\$50.00** charge for a cancellation without proper notice. This charge will probably not be covered by your insurance company, but will have to be paid by you personally.
- 3) You should understand that when you no-show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor and our staff, 2) the therapist who now has a "vacancy" in their schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.
- 4) **Regarding Lateness:** If you are late, you may not get in your full treatment because it would mean other patients are delayed.
- 5) **Regarding Being Early:** Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
- 6) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
- 7) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.
- 8) **Co-pays, deductibles, and payments** if you are a self-pay patient, are due at the time of service. We accept payments by credit card, check or money order **only.**
- 9) We will allow, on special occasions, a long term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
- 10) If at any point you have a problem regarding billing and payment, talk to our secretary and they will arrange for you to see our office manager.

After you have read carefully the above, please sign the following:

I _____, agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

Patient's Signature

Date



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CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although Hands-On is not required by law to obtain a signed consent from you for treatment, payment or healthcare operation purposes, we encourage you to sign this consent so that you are aware of our – and practices regarding protection of your personal health information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

The Notice is available by contacting the Privacy Officer. Please note that PhysioCare reserves the right to change the privacy practices described in the Notice. Should you wish to obtain a revised Notice, please contact the Privacy Officer.

By signing this consent, you agree that PhysioCare may use or disclose your protected health information to carry out treatment, payment, or health care operations.

You have the right to request that PhysioCare restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. However PhysioCare is not required to agree to such restrictions. If PhysioCare does agree to a restriction that you request you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that PhysioCare has taken action in reliance on your consent.

Acknowledgment and Agreement:

I consent to PhysioCare sending protected health information to the insured in the event I am receiving treatment but am not insured under my insurance policy. Such information may include, but are not limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected health information mailed to the insured, then I will notify PhysioCare of my objectives and will complete a request for Restriction of Use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously I understand that none of my protected health information may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I might inadvertently overhear about other patients while I' am receiving treatment in the open treatment area.

I consent to PhysioCare releasing my protected health information to the following individuals.

Name: _____ **Relationship to patient:** _____

Name: _____ **Relationship to patient:** _____

I have received a copy of PhysioCare Physical Therapy's Notice of Privacy Protection.

I hereby notify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

Patient's name: _____ **PhysioCare Universal ID #:** _____

Signature of Patient or Representative: _____ **Date:** _____

Name of personal Representative: _____

Relationship to patient: _____ \



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MEDICAL HISTORY

PAIN: Please rate your pain where 0 = No Pain and 10 = Maximum Pain: _____

PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:

- | | | |
|--|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Neck Injuries | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fractures (broken bones) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Back Injuries | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Whiplash | <input type="checkbox"/> Joint Strains |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Muscle Strains |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergies | <input type="checkbox"/> Gastrointestinal Problems |
| <input type="checkbox"/> Arthritis | | |

CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Muscular Pain with Exertion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling, Numbness or
Loss of Feeling |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Pain with Coughing or
Sneezing |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Change in Bowel And
Bladder Habits |
| <input type="checkbox"/> Muscular Pain at Rest | <input type="checkbox"/> Unusual Weakness | |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Blurred/Double Vision | |
| <input type="checkbox"/> Constant Pain Unrelieved
by Rest / Movement | <input type="checkbox"/> Unusual Skin Coloration | |

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS

DATE: _____
DATE: _____

DO YOU SMOKE? YES / NO. If Yes, How many pack per day? _____ **ARE YOU PREGNANT?** YES / NO

ARE YOU ALLERGIC TO ANY MEDICATION? YES / NO. IF YES, PLEASE LIST MEDICATIONS YOU ARE PRESENTLY TAKING:

PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?

- | | | |
|----------------------------------|-------------|----------------|
| <input type="checkbox"/> X-RAYS | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> MRI | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> EMG/NCV | DATE: _____ | RESULTS: _____ |

Is this your problem due to an injury / Work Related / A motor Vehicle Accident / or Other.
PLEASE DESCRIBE YOUR PROBLEM?

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN

- | | | | |
|---|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> CONSTANT | <input type="checkbox"/> INCREASING | <input type="checkbox"/> NIGHT PAIN | <input type="checkbox"/> DULL/ACHY PAIN |
| <input type="checkbox"/> INTERMITTENT | <input type="checkbox"/> DECREASING | <input type="checkbox"/> STIFFNESS | <input type="checkbox"/> SHARP PAIN |
| <input type="checkbox"/> PAIN UPON WAKING | <input type="checkbox"/> OCCASIONAL | <input type="checkbox"/> STATIC | |

PAIN IS **AGGRAVATED** BY: _____
PAIN IS **EASED** BY: _____

Have you been treated by a **Physical Therapist/Chiropractor?** YES / NO. If yes, approximate date _____
WHAT WERE YOU TREATED FOR? _____

I request that payment of authorized Medicare benefits be made on my behalf PhysioCare PT, PC. for services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I have provided all of the above information to the best of my knowledge at the time of this visit and will notify this office if any information above has changed during the care of PhysioCare PT, P.C.

Signature: _____ Date: _____



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PATIENT IN-TAKE SHEET

PATIENT DEMOGRAPHICS

New Patient

Previous Patient

Patient Name:		Title: Mr, Mrs, Miss	Gender: Female or Male
Social Sec. #		Employment: Y or N	Student: Y or N
Mailing Address:			
How Did You Hear About Us :			
Home #:	O.K to leave message: YES or NO	Best time to call:	
Work#:	O.K to leave message: YES or NO	Best time to call:	
Cell#:	O.K to leave message: YES or NO	Best time to call:	
DOB:	Marital Status:	E-Mail Address :	

ADMISSION INFORMATION

Start Care:	Date of Injury:
Region Affected:	Last MD visit:
Doctor's Name:	
Address:	
City:	State:
Zip Code:	Phone #
Specialty:	PCP: YES or NO

PRIMARY CARE PHYSICIAN

Doctor's Name:	
Address:	
City:	State:
Zip Code:	Phone #
Specialty:	PCP: YES or NO

Patient Employer:	
Address:	
City:	State:
Zip Code:	Phone #
Occupation:	

Spouse's Employer:	
Address:	
City:	State:
Zip Code:	Phone #
Occupation:	

PAYOR RESPONSIBILITY

Primary Insurance Name:	Co-pay Amount:
Group/Policy #:	ID#
**Secondary Insurance (If any)	**Co-pay Amount:
Insured's Name	Relationship to Insured: <input type="text"/>
Group/Policy #	ID#:

Worker's Compensation/No-Fault Information (if applicable)

Insurance Carrier (W/C)/(N/F):	
Insurance Carrier:	
WCC/NF CLAIM #:	
Type of Injury: (on the job?): <input type="text"/>	Date of Accident:
Attorney's Name:	Phone:

Patient's Signature: _____

Date: _____



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PRE-TREATMENT INSURANCE FORM

Verification Dept/Billing Representative: _____

0) Office Location: _____

1) Patient Name: _____

2) Health Insurance: _____
(Please verify with front desk any requirements required to proceed with Physical Therapy such as referral or pre-cert)

3) Social Security #: _____ **4) Date of Birth (DOB):** ____ / ____ / ____

5) Home Phone Number: () _____ **Cell:** () _____ **Work:** () _____

6a) Address: _____ Apt # _____
City, State, Zip Code

12) Is this a Workers Compensation Case? YES / NO (if NO, skip step 13)

a. Date of Accident: ____ / ____ / ____ b. Carrier: _____

c. WCB# or Case #: _____

d. Name of Adjuster: _____, Phone #: () _____

13) Is this a No-Fault Case? YES / NO (if NO, skip step 14)

a. Date of Accident: ____ / ____ / ____ b. N/F Claim #: _____

c. Carrier: _____ d. Attorney: _____

14) Referring MD: _____ **Diagnosis: (If known)** _____

15) Which body part(s) has your MD prescribed Physical Therapy for? (Please circle)

Neck Back Shoulder Elbow Wrist/Hand Knee

Ankle/Foot Hip Other: _____

16) Have you received prior Physical Therapy services for this problem this year?

YES [] If yes, describe frequency and duration of treatment: _____

NO [] If No, Have you received Physical Therapy Services this year for anything else? YES / NO

17) Have you ever received Physical Therapy Services? YES / NO

18) Date and Time of Appointment: ____ / ____ / ____ : ____ AM / PM

19) Name of Assigned Physical Therapist for Initial Evaluation (I.E.): _____

20) Attending Front Desk Name: _____ **Date:** ____ / ____ / ____