Rose Physical Therapy, PLLC

PATIENT INFORMATION FORM

Name: First_____ MI_____ Last_____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: Male Female E-mail Address: _____

Emergency Contact/Phone #: _____

Referring Physician: _____

Date of injury: _____

PRIMARY INSURANCE INFORMATION

Insurance company Name: _____

ID#:_____ Group #:_____

Name of Person Insured: _____ Relation: _____

Insured's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID#:_____ Group #:_____

Name of Person Insured: _____ Relation: _____

Insured's Employer: _____

NO-FAULT INSURANCE

No-Fault Carrier: _____

Carrier Address: _____

Date of Accident: _____ No-Fault Claim #:_____

WORKMAN'S COMPENSATION

WCB#: _____ Carrier Case#: _____

Employer: _____

Claims address: _____

Are you working? Yes or No Working with Restrictions? Yes or No

Rose Physical Therapy, PLLC

Name:_____ Today's date:_____

Age:_____ Occupation:_____

1. Where is your pain?

_____

2. When did it start?

_____

3. Is your pain the result of an injury?

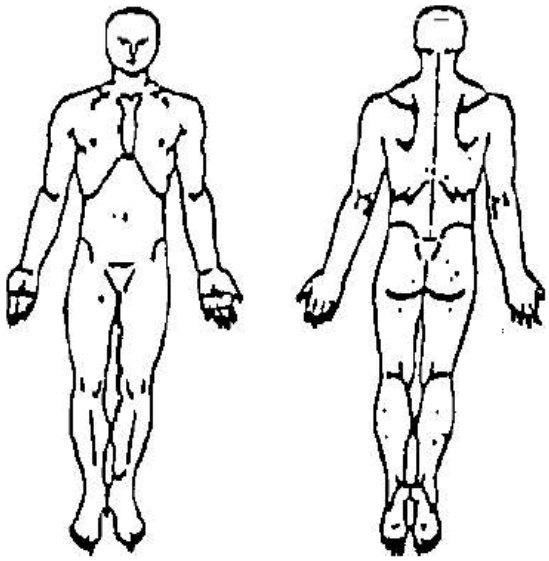
_____

4. Is your pain constant or intermittent?

5. Describe your pain:

Sharp Dull Achy Deep Burning Throbbing

Please draw pain pattern on the body chart below:



6. Rank your pain from a scale of 1 to 10 (10 is unbearable):

At rest_____ During activities_____

7. Is there anything that makes your pain better?

_____

8. Is there anything that makes your pain worse?

_____

9. What tests have you had recently?

MRI CT Scan X-Ray EMG

10. What activities do you have difficulties with?

Standing Sitting Walking Stairs Lying down

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MEDICAL HISTORY FORM

Name:_____ Age:_____

Please indicate if you have had or now have the following:

Condition	Yes	No	Condition	Yes	No
High Blood Pressure			Joint Replacement		
Heart Disease , Heart Attack, Pacemaker			Abdominal or Mid-Back pain		
Cancer			COPD/Asthma/Bronchiitis		
Osteoarthritis			Open Wounds		
Rheumatoid Arthritis			Skin Condition		
Diabetes			Metal Implant/Fragments		
Fracture			Osteoporosis		
Stroke or TIA			Vascular Problems		
Infectious Disease			Neck or Back Problems		
Seizures/Epilepsy			Fever and Chills		
COPD/Bronchitis/Asthma			Unexplained Weight Loss		
Joint Replacements			Pregnant Now		

If you marked yes above, please provide more information:

_____

_____

_____

Please list all previous surgeries:

_____

_____

_____

Please list all medications currently being taken (include over the counter and herbal supplements):

_____

_____

_____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
STATEMENT OF PRIVACY NOTICE

We may disclose your health care information:
1. To other health care professionals within out practice for the purpose of treatment, payment or health care operations.
2. To you insurance provider for the purpose of payment or health care operations.
3. To comply with State Workers' Compensation laws.
4. To Public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative or judicial proceeding or law enforcement purposes.

Under the HIPPA federal privacy law, you have the right to:
1. Request restrictions on certain uses and disclosures of your health information.
2. Inspect and copy your health care information.
3. Receive an accounting or disclosures of your protected health information made by us.
4. 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.
We are required by law to maintain the privacy of your health information.

If you have any questions regarding this notice or if you want more information about your privacy rights, please contact us at 716-204-8734.

My signature indicates my authorization and consent for Rose Physical Therapy, PLLC to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described above.

_____
Patient's Name (print)

_____
Patient's Signature Date

FINANCIAL POLICY
APPOINTMENT AND CANCELLATION POLICIES

We are committed to providing you with the best possible care. We will gladly discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Payment is due for services at the time services are rendered. This includes coinsurance, co-payments, and deductibles. We submit all billing to insurance companies. If a check is returned for insufficient funds, you will be changed a bank fee in addition to the amount of the check.

After the insurance company has paid their portion of your claim, you are responsible for any paid charges on your bill. You will have 90 days to pay your bill before it is turned over to a collection agency. You will be responsible for any fees the collection agency charges as well.

I understand than my doctor has prescribed physical therapy for me or I have chosen physical therapy without a doctor's referral. I understand that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress.

I give my permission for Rose Physical Therapy PLLC to provide information as needed to my insurance company.

APPOINTMENTS:
Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival time of greater than 15 minutes may be result in a shortened treatment or cancellation.

We require 24 hour notice of a cancellation or a $25 fee may be charged. You are directly responsible for this payment. Three episodes of not attending PT sessions without cancellation results in discharge.

_____

Signature of patient or guardian (if minor) indicates acknowledgment and agreement of above.