

# **W**elcome to RYE PHYSICAL THERAPY AND REHABILITATION!

Our team of experienced physical therapists is here to provide you with compassionate, innovation care to restore and/or achieve optimal movement and function and relieve your pain. We believe treatment success is a partnership-with you, our patient, and with your physician. It is important for you, therefore, to understand a little about how our office functions and to know about state and insurance requirements so that your treatments proceed uninterrupted and you achieve the best results possible.

**ABOUT OUR OFFICE HOURS AND YOUR APPOINTMENTS** Our office hours are Monday through Friday 6:00 a.m. to 7:30 p.m. and Saturdays 8:00 a.m. to 12:00 p.m. Sessions are by appointment only. Appointments should be scheduled at least one week in advance to ensure getting a timeframe most convenient for you.

We make every effort to see our patients on time and respect their schedules. Therefore, we request the same from them. We would appreciate your arriving 5-10 minutes earlier than your scheduled appointment. **Please check in at the front desk and then have a seat in the waiting room until you are called in by your therapist.** In order to respect the privacy of our patients we ask that you not enter the back treatment area, under any circumstances, unless you are directed to do so by office staff or therapists. If your appointment is in "off" hours (prior to 8:00 a.m.), take a seat in the waiting room where a therapist will be able to see you. If you are going to be late for an appointment, please call to see if the therapist can accommodate you or if rescheduling is required. If you arrive more than ten (10) minutes after your scheduled time, we reserve the right to cancel that visit and reschedule for another time.

## **APPOINTMENT CANCELLATIONS**

We require at least 24 hours advance notice for appointment cancellations. If our office is closed when you call, please leave a message on our answering machine. If you do not show up for a scheduled appointment, there will be a \$40.00 fee charged directly to you which is not reimbursable by insurance. Two consecutive "no-show" appointments will result in cancellation of all future appointments until you see your physician.

## **PARKING**

There are parking facilities at all three of our office locations.

**STATE AND INSURANCE REQUIREMENTS FOR PHYSICAL THERAPY:** While we will try to keep updated about the physical therapy benefits provided under your specific insurance plan, it is ultimately your responsibility to be knowledgeable about your benefits package. You need to know how often you are required to get a prescription from your physician for continued therapeutic care, whether or not you need pre-certification or authorization or another specialized form PRIOR to receiving care.

In addition to insurance coverage requirements, the State of New York requires that you provide us with a prescription for physical therapy services from your physician. Most prescriptions cover services from your initial visit through the time indicated on the prescription. If a timeframe is not indicated, then the prescription is valid for four (4) weeks from the start of care. It's up to you to check with your insurance company about requirements for physical therapy so that your care is not interrupted.

**MEDICARE PATIENTS:** If you are covered under Medicare, it is Federal policy that you see your physician every four (4) weeks to continue physical therapy. If you fail to do so, you will not be eligible to continue your care. In addition, if "objectively measurable progress" is not made over the course of a month, Medicare will consider further care as "maintenance care" and will not cover the cost of care. If, at that time, you want to continue therapy on your own, you will need to pay an out-of-pocket charge in accordance with the Medicare fee schedule. Any further questions about this issue can be discussed with your therapist.

**PAYMENT:** We ask that all co-payments be paid on the same day of service. We accept cash, Visa/Mastercard, American Express and checks as forms of payment. You can also pay for visits in bulk (i.e., per week, month, etc.).

I have read the above noted and understand the information provided.

Signature: \_\_\_\_\_

Dated: \_\_\_\_\_



This form can be completed on your computer, or printed and fill in by hand.

PATIENT INITIAL QUESTIONNAIRE

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

Are you a Workers' Compensation or No-Fault Case? Please Check One: YES NO

If Yes, Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you been treated by any other Physical Therapy Facility? Please Check One: YES NO

If yes, approximately when: \_\_\_\_\_

I authorize the release of any medical information pertinent to my examination or treatment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the information above and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's Signature (Parent if Minor): \_\_\_\_\_ Dated: \_\_\_\_\_

Please print this form, then sign in the space above.



**This form can be completed on your computer, or printed and fill in by hand.**

**RYE PHYSICAL THERAPY & REHABILITATION**  
Medical History and Systems Review

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery/Hospitalization/Reason
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains, strains) and the approximate date of injury:

Date	Injury
_____	_____
_____	_____
_____	_____

Please list any PRESCRIPTION or over-the-counter medication, vitamins/supplements that you are currently taking (including pills, injections and/or skin patches):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you or any of your family EVER been diagnosed as having any of the following:

**YOU                      FAMILY**

Cancer	YES
If YES, describe what kind: _____	
Heart Problems	YES
High Blood Pressure	YES
Asthma	YES
Emphysema	YES
Chemical Dependency (e.g. alcoholism)	YES
Thyroid Problems	YES
Diabetes	YES
Multiple Sclerosis	YES
Rheumatoid Arthritis	YES
Other Arthritic Condition	YES
Depression	YES
Hepatitis	YES
Tuberculosis	YES
Stroke	YES
Kidney Disease	YES
Anemia	YES
Epilepsy	YES
Are you Currently Pregnant?	YES
Osteopenia/Osteoporosis	YES
Other _____	YES

Date of last complete physical exam: Month \_\_\_\_\_ Year \_\_\_\_\_ Physician \_\_\_\_\_

RYE PHYSICAL THERAPY & REHABILITATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**HAVE YOU HAD, OR DO YOU EXPERIENCE:**

**Cardiovascular System**

**YES NO**

- Elevated cholesterol
- Sweating associated with pain
- Palpitations
- Swelling of extremities
- History of Smoking
- Orthopnea (difficulty breathing)

**GI System**

**YES NO**

- Difficulty swallowing
- Heartburn
- Jaundice (yellow appearance)
- Specific food intolerance
- Constipation
- Diarrhea
- Change in color of stool
- Rectal bleeding
- Gall bladder problems
- Liver Problems

**G.U. System**

**YES NO**

- Dysuria (painful urination)
- Hematuria (blood in urine)
- Incontinence
- Frequency of urination
- Urinary urgency
- Vaginal discharge
- Dysmenorrhea  
(painful menstruation)
- Post menopausal vaginal bleeding
- Painful intercourse
- Infertility
- History of STD
- Date of Last Period      \_\_\_/\_\_\_/\_\_\_

**Pulmonary System**

**YES NO**

- Dyspnea (labored breathing)
- Wheezing
- Prolonged Cough
- Sputum production  
amount/color: \_\_\_\_\_  
\_\_\_\_\_

**Endocrine System**

**YES NO**

- Excessive thirst
- Excessive hunger
- Polyuria (large volume of urine)
- Excessive sweating
- Fatigue
- Weakness
- Thyroid problems

**Neurological System**

**YES NO**

- Ataxia (poor muscular coordination)
- Memory Lapses
- Confusion
- Head Trauma
- Neurological disorder
- Tremors
- Slurred speech patterns
- Hearing/Visual disturbances

**Other Systems**

**YES NO**

- ENT (ears, nose, throat)
- Integumentary (skin)
- Lymphatic
- Psychiatric
- Musculoskeletal

# 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

## NOTICE OF PRIVACY PRACTICES

### OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office or otherwise brought to our attention. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the office personnel.

### USES AND DISCLOSURES

**TREATMENT:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**PAYMENT:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. Lastly, if necessary information may be used for an outside collection agency to collect any balance due to this facility. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**HEALTH CARE OPERATIONS:** Your health information may be used as necessary to support the day-to-day activities and management of Rye Physical Therapy & Rehab. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluation and promote quality.

**LAW ENFORCEMENT:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**APPOINTMENT REMINDERS:** Our practice may use and disclose your personal health information to contact you to remind you of a scheduled or missed appointment.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**ADDITIONAL USES OF INFORMATION:** Appointment reminders. Your health information will be used by our staff to confirm your first appointment with this facility.

**INFORMATION ABOUT TREATMENTS:** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**INDIVIDUAL RIGHTS:** You have certain rights under the federal privacy standards. These include:

- \* the right to request restrictions on the use and disclosure of your protected health information
- \* the right to receive confidential communications concerning your medical condition and treatment
- \* the right to inspect and copy your protected health information
- \* the right to amend or submit corrections to your protected health information
- \* the right to receive an accounting of how and to whom your protected health information has been disclosed
- \* the right to receive a printed copy of this notice

**DUTIES OF RYE PHYSICAL THERAPY & REHAB.:** We are required by law to maintain the privacy of your protected health information to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

**RIGHT TO REVISE PRIVACY PRACTICES:** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION:** You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Maryann Romero, Compliance Officer at 914-921-6061. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**COMPLAINTS:** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Maryann Romero, Compliance Officer  
Rye Physical Therapy & Rehab.  
266 Purchase Street, Rye, NY 10580

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

**EFFECTIVE DATE:** This notice is effective on or after January 1, 2003.

**RYE PHYSICAL THERAPY & REHAB.  
266 PURCHASE STREET  
RYE, NEW YORK 10580  
914-921-6061**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received and reviewed the Notice of Privacy Practices supplied to me by Rye Physical Therapy & Rehab. in compliance with the Federal Privacy Requirements by HIPAA.

I also verify that upon signing this acknowledgement I have been given a copy to retain for my records.

Lastly, the below stated names are additional individuals that information can be discussed with (i.e., appointments, billing, etc.). If no names are listed below, I realize that I personally am the only one that can discuss any information regarding physical therapy.

Names: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signed by:

\_\_\_\_\_  
Dated:

\_\_\_\_\_  
Print Name:

(REV. 5/14/03)