CENTER REHAB

BRIAN T. WILLIAMS M.S., P.T.
KELLY GAMMAGE P.T.
CHRISTOPHER OLIVEIRA P.T.
SARA G. RIEDEL P.T., C.S.C.S.

ORTHOPEDIC SPORTS PHYSICAL THERAPY EVALUATION & TREATMENT

155 HILL STREET
MILFORD CT 06460
WWW.CENTERREHAB.COM
PHONE: 203-882-9384
FAX: 203-882-9385

Thank you for choosing Center Rehab. This package is designed to make getting started on your recovery easy. By completing the forms you just printed from our website at home, you can take your time and check to be sure the information is correct and complete. This will help prevent mistakes and will ultimately give you more time with your therapist on your first day. Here are a few tips before you arrive:

- ☑ Bring your completed forms with you.
- ☑ Arrive 15 minutes early the first day to complete registration.
- ☑ Parking is located in a smaller lot in front of the office door. Look for our sign on the building. Additional space is located in a larger lot nearer to the corner.
- ☑ Wear comfortable clothing such as shorts or loose pants and a t-shirt. Avoid skirts, heels, jeans and dress clothes. Bring a change of clothes with you if you are coming from work.
- ☑ Bring your physical therapy prescription with you if you saw the doctor.
- ☑ Bring your insurance card or auto policy info and a picture ID.
- ☑ We run very close to scheduled times, so please be prompt.
- ☑ Plan to spend an hour with your therapist on your first visit.

Insurance Information

Please complete all areas of this form that apply to you.

To Be Completed By The Patient

Name of Patient_____

Home Address (no P.O. Boxes)_____

City_____ State_____ Zip_____ Birthdate_____/ _____/ _____

S.S. #_____ Email_____

Best phone number to reach you & leave messages is:

(_____)_____ Cell / Home / Work (circle one)

Secondary number/Emergency Contact _____#_____

How Did You Hear of Center Rehab?

Doc___ Friend___ Internet___ Facebook____ IG____ Ins Co.___ Other_____

We ask that all Insurance source benefits are paid directly to Center Rehab **YES** / No
(If no, then payment is due on date of visit)

To Be Completed By The Policy Holder If Different

Name of Insured_____ Date of Birth_____/ _____/ _____

Home Address (no PO Boxes)_____

Complete For Workers Compensation Only

Employer/Address_____

Contact Person_____ Phone_____

Case Number_____ Case Worker_____

Insurance Company_____

The Above Information Is Complete And Accurate:

Signature_____ **Date**_____
(Guardian if patient under 18 or responsible person)

revised 12-11-2018

Center Rehabilitation Confidential Patient Medical History

Name: _____ Date: _____

Age:_____ Height:_____ Weight:_____

Why did you come to see a Physical Therapist? _____

Have You Recently Had:	**Circle One**	**Comments**
Weight Loss / Gain?	Yes / No	
Loss of appetite?	Yes / No	
Unexplained fevers / chills/ sweats?	Yes / No	
Fatigue / tiredness?	Yes / No	
Urinary or bowel problems?	Yes / No	
Nausea and vomiting?	Yes / No	
Numbness or tingling?	Yes / No	
Coordination problems?	Yes / No	
Difficulty walking?	Yes / No	
Dizziness or loss of consciousness?	Yes / No	
Loss of balance or falls?	Yes / No	
Chest pain or palpitations?	Yes / No	
Shortness of breath?	Yes / No	
New onset of headaches?	Yes / No	
Visual problems?	Yes / No	
Hearing problems?	Yes / No	
Have you been told that you have:	**Circle One**	
High blood pressure?	Yes / No	
Heart problems (including pacemaker)?	Yes / No	
Lung problems?	Yes / No	
Kidney problems?	Yes / No	
Head injury?	Yes / No	
Multiple Sclerosis / Parkinson's Disease?	Yes / No	
Stroke / Neurological problems?	Yes / No	
Liver problems?	Yes / No	
Thyroid problems?	Yes / No	
Blood disorders or anemia?	Yes / No	
Diabetes (high blood sugar)?	Yes / No	
Low blood sugar?	Yes / No	
Seizures?	Yes / No	
Cancer?	Yes / No	
Arthritis?	Yes / No	
Tuberculosis?	Yes / No	

Have you been told that you have:	**Circle One**	**Comments**
Repeated infections/immune problems?	Yes / No	
Osteoporosis?	Yes / No	
Circulation or vascular problems?	Yes / No	
Broken bones/fractures?	Yes / No	
Ulcers/stomach problems?	Yes / No	
Do you smoke?	Yes / No	
For Men Only:		
Prostate Problems?	Yes / No	
For Women Only:		
Gynecological/Pelvic problems?	Yes / No	
Problems with your period?	Yes / No	
Are you pregnant or think you might be?	Yes / No	
Complicated pregnancies/deliveries?	Yes / No	

Do you have any other medical problems? Please List_____

_____

What prescription and non-prescription medications/drugs do you take? _____

_____

Please list any **allergies** to latex, lotions, gels, products or any medications_____

_____

Have you been hospitalized or had surgery in the past? If so, when and for what?_____

_____

_____

Have you seen anyone else for this problem? Please check all that apply.
Physician___ Osteopath (D.O.)___ Physical Therapist____ Chiropractor____ Podiatrist____
Dentist____ Other_____

Have you recently had diagnostic tests? (i.e. X-rays, CT scan, MRI, bone density, stress test etc.) Please list._____

_____

If you are being seen without a doctor's referral, who is your primary care physician?

_____

_____ _____
Patient Signature Date

CONSENT, PAYMENT AND BILLING INFORMATION - PLEASE READ CAREFULLY

Your Insurance: Co-pays, if required by your insurance, are due at the time of each treatment session. Fees will apply if we have to bill you for co-pays or other time-of-service payments. Your insurance plan may require that we seek their approval to begin treatment. You agree to allow us to bill your insurance company or payment source and authorize all payments for services to be made directly to Center Rehabilitation & Sports Therapy. You may self-pay for all treatment charges yourself if you wish.

Auto Injury Cases: In cases involving motor vehicle accident related injuries, we will need insurance information on your vehicle. You need to provide your private insurance information as well. If a lawyer is representing you, we will need that person's name. We will determine eligibility. Co-Pays and deductibles are due with each visit if you use your health insurance, even if you have a lawyer involved. If a suit is involved, you agree to payment from proceeds of the case (should it be successful) once the insurance is exhausted.

Balances: Any balance which is not covered by your payment source(s) and is determined to be the responsibility of the insured and/or treated individual will be past due after 30 days unless a payment schedule is arranged in writing. A monthly late fee charge of 20% will be applied to any overdue balances. The undersigned will be responsible for reasonable fees and other costs of suit or collection, including lawyers and court expenses on unpaid balances. Any returned checks will be assessed an additional penalty of 50% of the amount plus bank fees. We may require a credit card be placed on file for balances.

Cancellation: Please give us the courtesy of 24 hours notice for cancellation and rescheduling of your appointment. Unfortunately, 2 or more late cancellations (or "No-Show" episodes) will result in a $50.00 charge being applied to your account. The fee must be paid before you have more treatment. Arriving late means your treatment session will be shortened. Arriving 15 minutes late or more to your appointment counts as a No-Show. Try to call so we know you are coming. If we can reschedule you on the same day, you won't be charged a fee.

Privacy: An up to date copy of our privacy practices are available for viewing in the waiting area at all times. It contains important details about how we handle your personal information. Please take the time to read it carefully. You will receive a copy on your first visit.

Consent: I request and give my consent to Center Rehab to provide me (or my minor child) with physical therapy care. I understand I am responsible for clearly communicating my pain levels, history, limitations, goals and other needs during my course of treatment. Once a plan is agreed upon, I understand I must participate as recommended in my treatment to maximize my recovery. I will be informed by a physical therapist of the risks and benefits of treatment options.

I have read, understand and agree to the statements above:

Patient Signature_____ **Date**_____

(Guardian if patient under 18 or responsible person)

Revised 12-11-18

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Authorization For Medical & Personal Information Release

I hereby authorize Center Rehabilitation & Sports Therapy LLC, to release my medical records and personal data including all information regarding my condition, bills, records, diagnosis and prognosis only to those entitled to this information as required by insurance contract, law, other third party payers, or as ordered by the State or Federal Court. If this is a workers compensation case, your employer is entitled to this information by law. This information will be handled and protected from unauthorized disclosure in a manner specified by Federal and State privacy laws and in keeping with our own protected information policy.

Further, you authorize at this time, your Doctor or other medical specialist, laboratory or diagnostic imagining center to release relevant medical records, test results and imaging information to Center Rehabilitation & Sports Therapy.

Finally, you authorize Center Rehabilitation & Sports Therapy LLC to communicate regularly with your doctor(s) and their office(s) to ensure coordinated care via direct consultation, phone calls, faxed/mailed written correspondence and encrypted email. Medical and personal information in our files will be provided to those not mentioned above only if we receive additional authorization for such release signed by you or your legal guardian.

A photocopy or facsimile of this form will be considered valid and enforceable.

⇨**May we leave appointment reminder messages on your cell phone?**
Yes___ No__

Cell #: _____

Print Patient Name_____

Signature_____ Date_____
(Guardian if patient under 18 or responsible person)

Revised 12-11-2018

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NOTICE OF PRIVACY PRACTICES

This document describes the privacy practices of Center Rehab regarding the handling your private health information. All professional, administrative, partner and volunteer members of our office are asked to adhere to these practices. Please read this document carefully before you sign it. If you have any questions, you may ask the administrative staff for help or you can contact our in-house security officer, Sara Riedel PT.

WHAT'S PROTECTED?

The personal and health information you give us or that we obtain from your doctor's office or diagnostics lab are examples of protected information. Information we generate such as billing and payment data, reports, letters, logs and treatment notes are also protected. Phone conversations and electronic communications regarding your care and information are also included.

HOW DO WE USE AND DISCLOSURE OF YOUR PROTECTED INFORMATION?

We will use and share your information within our office among staff involved in your care and in the support of your care. Administrative use of your information is also necessary to perform insurance authorizations, billing, collections and follow-up.

We will leave 'reminder calls' on a phone line you designate in your intake paperwork to remind you of your next visit. Brief messages regarding your care or administrative issues may also be left on this line. You may opt-out of reminder calls. Discuss this with the administrative staff.

If you have a lawyer involved with your care, we communicate with that office to the extent you have provided an appropriate release for such communication.

Your referring provider's office will also receive information relevant to your care in the form of reports, care plans, attendance records, etc. for medical care coordination and administrative management. For example, we may use fax, electronic communications, phone or in-person conversations. You can ask us to communicate with additional medical offices of your choosing. For example, if your Internist refers you to us but then additionally refers you to see an orthopedist. With your written permission, we will communicate with that office as well. If you wish us to stop exchanging protected information with a referring provider, you must provide written notice.

Your payment source for your care will also receive communications about your protected information as required by law or contract in the performance of authorizing care, billing and collections activities. Third party payment sources generally require us to disclose your protected information as a condition of payment.

Law enforcement or government agencies may lawfully request your protected information. When we are required by law to provide your protected information we will. Subpoena or court order will also require us to forward your protected information. You cannot opt out of this particular potential disclosure.

In cases of emergency where you are unable to give or decline consent, we will provide any information that we feel will be helpful in rendering care to you by emergency services. In cases where abuse, neglect or criminal action is suspected, we reserve the right to report these issues to the proper authorities.

WHAT ARE YOUR RIGHTS?

You can control who has access to your protected information. You can halt or change who you want us to share or not share your protected information. This includes but isn't limited to: Your referring provider, lawyer, family/friend, insurance or payment source, or other involved parties. You can prevent us from sharing this information with specific entities or individuals by listing them below. You can request to amend this at any time by asking the Center Rehab administrative staff for another disclosures form.

Most payment sources require disclosure of your protected information as a condition of payment. If you exercise your right to decline permission for this disclosure, we will require you to pay for your treatment services directly.

You have a right to a full copy of your health record and who it's been shared with. Please allow 48 hours for us to ensure we gather everything.

You have a right to designate (or undesignate) someone to act for you in matters of your care and disclosure of your protected information.

You have a right to file a complaint if you feel your protected information has been mis-handled. You can do so with the Center Rehab security officer at our address or phone number noted above, or by calling the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.S., Washington D.C. 20201 or by calling them at 1-877-696-6775.

You may ask us to correct health information about you that you think is incorrect or incomplete by submitting the request in writing to the Privacy officer along with supporting documentation. We may not agree and deny your request but your request will be made part of your record.

OUR RESPONSIBILITIES.

We will follow the privacy practices in this document and provide you with a copy.
We will alert you promptly if there is a breach of your protected information by an unauthorized source.
We will amend who has access to your protected information once we receive your request in writing.
We will maintain a password protected computer system and maintain secure up-to-date software as well.
We will maintain a secure physical location which houses your protected information.

Changes to the policy that guides our handling of your protected information can be made without notifying you. The new notices will be available in person in the office and online via our website www.CenterRehab.com.

I have received, read and understand how my protected information will be handled by Center Rehab.

I do NOT want disclosures made to the following:_____

Print:_____

Signed:_____

Date:_____

Directions

to

Center Rehabilitation & Sports Therapy

155 Hill Street
Milford, CT 06460
Phone ⇨ 882-9384

*****PLEASE ARRIVE 15 MINUTES EARLY ON THE FIRST DAY*****

From Merritt Parkway:

- ☑ Exit 54 and follow the connector to the 3rd exit.
- ☑ Go through the stop sign to the traffic light.
- ☑ Turn right on to the Boston Post Road (Route 1) and drive about 1 mile.
- ☑ Turn left on to West Clark Street at Gusto Restaurant.
- ☑ Turn right at the second stop sign on to Hill Street.
- ☑ We are the first building on the left. Turn into the third driveway.

From I 95:

- ☑ Exit 36 (Plains Road).
- ☑ Turn **right** if you came traveling I95 North or **left** if you came traveling I95 South on to Plains Road.
- ☑ Travel straight across the Boston Post Road (Route 1) on to West Clark Street.
- ☑ Turn Right at the second Stop Sign on to Hill Street.
- ☑ We are the first building on the left. Turn into the third driveway.

From the Milford Green Area:

- ☑ From the Milford Green drive past Milford Hospital on Bridgeport Avenue.
- ☑ Turn right onto Clark Street (at Wayne Tire/Carvel Ice Cream).
- ☑ Follow Clark Street over the railroad tracks.
- ☑ Turn left at the first stop sign onto Hill Street.
- ☑ We are the first building on the left. Turn into the third driveway.

From the Boston Post Road (Rt 1):

- ☑ Turn onto West Clark Street at Gusto's Restaurant.
- ☑ Turn Right at the second Stop Sign on to Hill Street.
- ☑ We are the first building on the left. Turn into the third driveway.