TENDER LOVING CARE, P.T, P.C

PATIENTIN TAKESHEET

PATIENTDEMOGRAPHICS **NewPatient** ☐ **PreviousPatient** ☐

PatientName:	**Title:** Mr., Mrs., Miss	**Gender:** Female or Male
SocialSec.#	**Employment:YorN**	**Student:YorN**
MailingAddress:		
Email Address:		
Home#:	**O.Ktoleavemessage:** YESor NO	**Besttimetocall:**
Work#:	**O.Ktoleavemessage:** YESor NO	**Besttimetocall:**
Cell#:	**O.Ktoleavemessage:** YESor NO	**Besttimetocall:**
DOB:	**MaritalStatus:**	

ADMISSIONINFORMATION

StartCare:	**DateofInjury:**
RegionAffected:	**LastMDvisit:**
Doctor'sName:	
Address:	
City:	**State:**
ZipCode:	**Phone#**
Specialty:	**PCP:YESorNO**
Doctor'sName:	
Address:	
City:	**State:**
ZipCode:	**Phone#**
Specialty:	**PCP:YESorNO**

EMPLOYMENTINFORMATION

PatientEmployer:	
Address:	
City:	**State:**
ZipCode:	**Phone#**
Occupation:	
Spouse'sEmployer:	
Address:	
City:	**State:**
ZipCode:	**Phone#**
Occupation:	

PAYORRESPONSIBILITY

PrimaryInsuranceName:	**Co payAmount:**
Group/Policy#:	**ID#** }
****SecondaryInsurance(Ifany)**	****Co payAmount:**
Insured'sName	**RelationshiptoInsured :**
Group/Policy#	**ID#:**

WORKER'SCOM PENSATION/NO FAULTINFORMATION(IFAPPLICABLE):

InsuranceCarrier(W/C) /(N/F):	
InsuranceCarrier:	
WCC/NFCLAIM#:	
TypeofInjury:(onthejob?):	**DateofAccident:**
Attorney'sName:	**Phone:**

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MEDICAL HISTORY

PAIN:PleaserateyourpainwhereO=NoPainand10=MaximumPain:_____

PLEASEMARKTHEFOLLOWINGIFYOUHAVEHAD:

____Angina
____HeartAttacks
____Stroke
____HeartSurgery
____Tumors
____Diabetes
____Epilepsy
____Arthritis
____Osteoporosis
____NeckInjuries
____Fractures(brokenbones)
____Backinjuries
____Whiplash
____Circulatoryproblems
____Allergies
____HeartDisease
____Cancer
____Highbloodpressure
____Lungdisease
____Jointstrai ns
____Musclestrains
____ Gastrointestinal problems

CHECKTHEFOLLOWINGBOXESIFYOUHAVERECENTLYEXPERIENCED:

____Headaches
____Muscularpainwithexertion
____Falls
____Tremors
____Musculerpainatrest
____Difficultysleeping
____Consta ntPainunrelieved byrest/movement
____Shortnessofbreath
____Dizziness
____Balanceproblems
____Unusualfatigue
____Unusualweakness
____Blurred/doublevision
____Unusualskincoloration
____Unexplainedweightloss
____Tingling,numbnesso r lossoffeeling
____Painwithcoughingor sneezing
____Changeinboweland bladder habits

PLEASELISTANYMAJORSURGERIESANDHOSPITALIZATIONS

_____ _____ _____ DATE:_ _____
_____ _____ _____ DATE:_ _____

DOYOUSMOKE? YES/NO.IfYes,Howmanypackperday ? _____ **AREYOUPREGNANT** ? YES/NO

AREYOUALLERGICTOANYMEDICATION? YES/NO. IFYES,PLEASELISTMEDICATIONSYOUAREPRESENTLYTAKING:

_____
_____

PLEASEMARKTHEFO LLOWINGIFANYOFTHESEDIAGNOSTICTESTSHAVEBEENPERFORMED?

___ X RAYS DATE:_ _____ RESULTS:_ _____
___ MRI DATE:_ _____ RESULTS:_ _____
___ EMG/NCV DATE:_ _____ RESULTS:_ _____

Isthisyourproblemduetoaninjury/WorkRelated/AmotorVehicleAccident/orOther.
PLEASEDESCRIBEYOURPROBLEM?

_____
_____

PLEASECHECKTHEFOLLOWINGWHICHBESTDESCRIBEY OURPAIN

____CONSTANT ____INCREASING ____NIGHTPAIN ____DULL/ACHYPAIN
____INTERMITTENT ____DECREASING ____STIFFNESS ____SHARPPAIN
____PAINUPONWAKING ____OCCASIONAL ____STATIC

PAINIS **AGGRAVATED** BY:_ _____
PAINIS **EASED** BY:_ _____

Haveyoubeentreatedbya **PhysicalTherapist/Chiropractor** ? YES/NO.I fyes,approximatedate_____
WHATWEREYOUTREATEDFOR ?_____

Irequestthatpaymentofauthorized Medicarebenefitsbemadeonmybehalfto TLC,P.T forservicesfurnishedtomebymy provider.Iauthorize anyholderofmedicalinformationaboutmetoreleasetothe HealthCareFinancingAdministrationandits agentsanyinformationneededtodeterminethesebenefitspayableforrelatedservices.Ihaveprovidedalloftheabove informationtothebestofm yknowledgeatthetimeofthisvisitandwillnotifythisofficeifanyinformationabovehaschanged duringthecareof TLC,P.TPhysicalTherapy .

Signature:_____ _____ _____ Date:_____

TENDER LOVING CARE, P.T, P.C

REGISTRATION FORM

InOrdertoacceptyourinsuranceassignmentthefollowinginformationisneeded:

A) Patient'sName_____ SS#_____

B) Patients

Address_____

_____

C) DateofBirth_____

D) SexM_____F_____

E) Relationshiptoinsured_____

F) InsuredName&SS#_____ _____

G) Istheinsuredcurrentlyworking?Yes_____No_____

H) IsthisaManagedCareplan?Yes_____No_____

I) IsthisaHMO?Yes_____No_____

J) NameandaddressofInsurancevendor

_____

_____

K) IDNumber_____

L) Precert/Authorization_____

M) Insuredem ployername&address_____ _____

_____

N) SecondaryHealthInsurance_____ _____

_____

Patient'sSignature_____Date_____

TENDER LOVING CARE, P.T, P.C

CONSENT TO USE/DISCLOSE HEALTH INFORMATIONFORM

Although TLC,P.T isnotrequiredbylawtoobtainasignedconsentfromyoufortreatment,paymentorhealthcare operationpurposes,weencourageyoutosignthisconsentsothatyouareawareofour – andpracticesregarding protectionofyo urpersonalhealthinformation.

Shouldyoudesireamorecompletedescriptionofthepermissibleusesanddisclosuresofyourprotectedhealth information,youhavetherighttoreviewaNoticeofPrivacyPractices(the"Notice")priortosigningthiscon sent.

TheNoticeisavailablebycontactingthePrivacyOfficer.Pleasenotethat TLC,P.T reservestherighttochangethe privacypracticesdescribedintheNotice.ShouldyouwishtoobtainarevisedNotice,pleasecontactthePrivacy Officer.

Bysig ningthisconsent,youagreethat TLC,P.T mayuseordiscloseyourprotectedhealthinformationtocarryout treatment,payment,orhealthcareoperations.

Youhavetherighttorequestthat TLC,P.T restricthowyourprotectedhealthinformationisused ordisclosedto carryouttreatment,payment,orhealthcareoperations.However TLC,P.T isnotrequiredtoagreetosuch restrictions.If TLC,P.T doesagreetoarestrictionthatyourequestyourequest,suchrestrictionwillbebinding.

Youhavethe righttorevokethisconsentinwriting,exceptttotheextentthat TLC,P.T hastakenactioninreliance onyourconsent.

AcknowledgmentandAgreement :

Iconsentto TLC,P.T sendingprotectedhealthinformationtotheinsuredintheeventI'amreceivin gtreatmentbut amnotinsuredundermyinsurancepolicy.Suchinformationmayinclude,butnotbeinglimitedto,explanationof benefits("BOB")orinvoicesregardingmytreatment.IunderstandthatifIdonotwantsuchprotectedhealth informationmail edtotheinsured,thenIwillnotify TLC,P.T ofmyobjectivesandwillcompletearequestfor RestrictionofuseandDisclosureform.

Inaddition,Iunderstandandacceptthe riskofunintentionaldisclosureofmyprotectedhealthinformation becauset hetreatmentareaisanopenareawhereIandotherpatientsaretreatedsimultaneouslyIunderstandthat noneofmyprotectedhealthinformationmaybeinadvertentlyoverheardbyotherpatientsand/ortherapists.Ialso agreenottodiscloseanyprotected healthinformationthatImightinadvertentlyoverhearaboutotherpatients whileI'amreceivingtreatmentintheopentreatmentarea.

Iconsentto TLC,P.T releasingmyprotectedhealthinformationtothefollowingindividuals.

Name:_____ **Relationshiptopatient:**_____

Name:_____ **Relationshiptopatient:**_____

Ihavereceivedacopyof TLC,P.T PhysicalTherapy'sNoticeofPrivacyProtection.

IherebynotifythatIhavereadt heprovisionssetforthinthisconsent.Iunderstandandagreetothetermsofthis consent.

Patient'sname : _____ **UniversalID#:**_____

SignatureofPatientorRepresentative : _____ **Date:**_ _____

NameofpersonalRepresentative :_ _____

Relationshiptopatient :_ _____

TENDER LOVING CARE, P.T, P.C

EXPLANATION OF PROCEDURES

Welcometoourpractice.Youareherebecauseyouhavebeenreferredt ousbyyourdoctorforPhysicalTherapy. PhysicalTherapyisdefinedas:“Theevaluation,treatmentorpreventionofdisability,injury,diseaseorother conditionofhealthusingphysical,chemicalandmechanicalmeansincluding,butnotlimitedtoheat, coldlight,air water,soundelectricity,massage,mobilizationandtherapeuticexercise…”

HereistheexplanationofsomeofthePhysicalTherapyproceduresandmodalitiesthatyoumayreceiveduring yourcourseoftreatmentwithus.Pleasemakesureth atifyouhaveanyquestionyouaskyourPhysicalTherapist toanswerthemtoyoursatisfaction.

PHYSICALTHERAPYEVALUATION(97001): Thisincludestakingacomprehensivehistory,systemsreviewand testsandmeasurements.ThePTwillformulateanassess ment,prognosisandnoteanticipatedintervention.

PHYSICALTHEREAPYRE EVALUATION(97002): ThePTreexaminesthepatientandupdatesgoalsand treatmentplan.

THERAPEUTICEXERCISE(97110): Therapeuticexercisestodevelopstrengthand endurance rangeof motionand flexibility.

NEUROMUSCULARRE EDUCATION(97112): Neuromuscularreeducationofmovement,balance, coordination,kinestheticsense,postureand proprioception.

AQUATICTHERAPY(97113): Aquatictherapywiththerapeuticexercises.

MANUALTHERA PY(97140): Manualtherapytechniquesmayincludemobilization,manipulation,manual lymphaticdrainage,manualtraction,softtissuemobilization.

THERAPEUTICACTIVITIES(97530): Useofdynamicactivitiestoimprovefunctionalperformance(activities suchasbending,lifting,carrying,reachingetcandhaveasagoaltoimproveyourfunctionalperformanceina progressivemanner).

ELECTRICALSTIMULATION(97014&ULTRASOUND(97035): Thesearephysicalagents,usedinconjunction withtheothertreatments toreducepain,inflammationetc.

GAITTRAINING(97116): Gaittrainingactivitiesincludingstairclimbing.

SELFCARE,HOMEMANAGEMENTTRAINING/ADLTRAINING,SAFETYPROCEDURESECT:(97535)

GROUPTHERAPEUTICPROCEDURE(97150): Landoraquaticgroupbas edactivities.

MASSAGE(97124): Effleurage,petrissageandor/tapotement(stroking,compressionetc)

BYSIGNINGTHEISDOCUMENTIACKNOWLEDGETHATIUNDERSTANDTHATIMAYRECEIVEA NUMBEROFTHEABOVELISTEDSERVICESANDALLOFMYQUESTIONSWEREANSWER EDBYTHE TREATINGTHERAPISTTOMYSATISFACTION.

_____	_____	_____	_____
Patient’sName	**Signature**		**Date**

1.AmericanPhysicalTherapyAssociation.GuidetophysicalTherapyPractice.Alexandri a,VA:APTA;1999
2.HCFAMedicare.PhysicalMedicine&Rehabilitation.PolicyNumber(YPF#86)(YMED#09)MNBMedicare;2002

TENDER LOVING CARE, P.T, P.C

DearPatient,

Welcometoourpractice.Thankyouforyourconfidenceandtrustinschedulinganap pointment withourclinic.Wearealwaysdedicatedtoqualitycareforallourpatientsandwearealwayshereto discussyourproblemsandfindtogetherthemostappropriatesolution.Ourofficepatientpoliciesareas follows.Pleasereadcarefullyth efollowingpoliciesandsignbelow.

GENERAL OFFICE POLICIES

1) Werequire24hoursnoticeintheeventofacancellation.Itisyourresponsibility,whenyoucallin ***to haveanalternativetimeinmindthatwillensureyougetinthefullprescribednumbe roftreatments thatweekwheneverpossible.***
2) Thereisa **$50.00** chargeforacancellationwithoutpropernotice.Thischargewillprobablynotbe coveredbyyourinsurancecompany,butwillhavetobepaidbyyoupersonally.
3) Youshouldunderstandthatwhen youno show,threepeoplegethurt:1)yourselfbecauseyoudon't getthetreatmentyouneedasprescribedbythedoctorandourstaff,2)thetherapistwhonowhasa "vacancy"intheirschedulesincethetimewasreservedforyoupersonally,and3)anoth erpatient whocouldhavebeengiventreatmentifyouhadgivenuspropernotice.
4) **RegardingLateness:** Ifyouarelate,youmaynotgetinyourfulltreatmentbecauseitwouldmean otherpatientsaredelayed.
5) **RegardingBeingEarly:** Mostofthetimeyou'll havetowaituntilyourscheduledtimetobeseen becausethereareotherpatientswhoarestillintreatment.
6) Foryourhealth'sbenefitwehavedevelopedbothaformalevaluationprocessandadischarge process.Ineachofthese,thePhysicalTherapist preparesareportforyourdoctor.
7) Pleaseunderstandthatyourinsurancepolicyisacontractbetweenyouandyourinsurance company.Whilewemayacceptyourinsuranceaspayment,yourcontractwithusisaseparate agreement.Inotherwords,ifyourin surancerefusestocoveracertaintreatmentorotherwisefailsto payus,yourcontractwithusstillexists,andyouareresponsibleforpaymentpersonally.
8) ***Co pays,deductibles,andpayments*** ifyouareaself paypatient,aredueatthetimeofservice. We acceptpaymentsbycreditcard , check,cashormoneyorder **only.**
9) Wewillallow,onspecialoccasions,alongtermpaymentplanbudgetedontheindividualaccording toneed.Inanyevent,ifyourequestsuchaplan,youwillsignawrittenagreement whichmustbe givenfinalapprovalbytheClinicalDirector.
10) Ifatanypointyouhaveaproblemregardingbillingandpayment,talktooursecretaryandtheywill arrangeforyoutoseeourofficemanager.

Afteryouhavereadcarefullytheabove,pleases ignthefollowing:

I_____,agreetobetreatedinthisPhysicalTherapyclinicby thePhysicalTherapistandtheirstaffandIalsoagreewiththetermsspecifiedabove.

_____ _____

PatientsSignature **Date**

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say “yes” to all reasonable requests.

Your Information.
Your Rights.
Our Responsibilities.

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.

Tender Loving Care Physical Therapy, P.C.

3555 Bainbridge Avenue, Bronx New York 10467. Tel. # 718-652-3535.Web: www.tenderlovingcarept.org

If you have any questions about this notice, please contact : Jorge L. Llaurado, PT at (718)652-3535 or at jllaurado@juno.com

Ask us to limit what we use or share

• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say “no” if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

• We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

• Include your information in a hospital directory
• Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

• Marketing purposes

• Sale of your information

• Most sharing of psychotherapy notes

In the case of fundraising:
• We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you •
We can use your health information and share it with other professionals who are treating you.

Example:
A doctor treating you
for an injury asks another doctor
about your overall health condition.

Run our organization
• We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example:
We use health information about you to manage your treatment and services.

Bill for your services
• We can use and share your health information to bill and get payment from health plans or other entities.
Example:
We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**
Help with public health and safety issues
• We can share health information about you for certain situations such as:

• Preventing disease

• Helping with product recalls

• Reporting adverse reactions to medications

• Reporting suspected abuse, neglect, or domestic violence

• Preventing or reducing a serious threat to anyone's health or safety

Do research
• We can use or share your information for health research.

Comply with the law
• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
• We can use or share health information about you:

• For workers' compensation claims

• For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of Your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.
Effective Date of this Notice: September 1, 2013
Tender Loving Care Physical Therapy, P.C.
For privacy matters contact Jorge L. Llaurado at jllaurado@juno.com